

Independence

trustworthiness

accountability

vigilance

integrity

Police response to events preceding the
murder of Diane White

February 2013



February 2013

IPCA
Level 8
342 Lambton Quay
PO Box 5025
Wellington 6145
Aotearoa New Zealand
0800 503 728
P +64 4 499 2050
F +64 4 499 2053
www.ipca.govt.nz



Contents

INDEPENDENT POLICE CONDUCT AUTHORITY

Introduction	3
Executive Summary.....	7
Background	11
Applicable Laws and Policies.....	31
The Authority’s Investigation.....	39
The Authority’s Findings	41
Subsequent Police Action	57
Conclusions	63
Recommendations	65



Introduction

INDEPENDENT POLICE CONDUCT AUTHORITY

1. On Tuesday 19 January 2010, Police were notified that Christine Judith Morris, a patient at the Henry Rongomau Bennett Centre (HBC) in Hamilton, had escaped after threatening to kill her next-door neighbour, Diane Elizabeth White.
2. Police later found Mrs White dead in her home. She had been killed by Ms Morris, who was then quickly located and taken into Police custody.
3. Police notified the Independent Police Conduct Authority of the death of Mrs White, and the Authority conducted an independent investigation. This report details the Authority's investigation, findings and recommendations.
4. The report focuses upon the actions of Police from the time they were notified that Ms Morris had escaped from the HBC until she was arrested.
5. The Authority has no jurisdiction to review or comment on the Court's findings in relation to Ms Morris, or on the actions of any person other than Police involved in this case.

Glossary of terms

Abbreviation/term	Explanation
ASOPs	Administrative standard operating procedures (for Police Communications Centres).
CAD	Computer-assisted dispatch system Communicators create 'events' within the CAD system and record the information they have obtained from the caller – once the information is entered into the system the dispatcher is able to read it.
Communicator	Based at the Communications Centre and is responsible for answering and prioritising calls. Previously known as 'call taker'.
Crime Reporting Line (CRL)	A designated crime reporting service to receive and action non-emergency calls.
Dispatch	To task and/or move a resource.
Dispatcher	Based at the Communications Centre. Receives an event that has been entered into the computer assisted dispatch system by a communicator and allocates the job to a patrol or patrols in that area according to availability and priority.
DAO	Duly authorised officer A mental health professional, defined by section 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 as: <i>"a person who, under section 93, is authorised by the Director of Area Mental Health Services to perform the functions and exercise the powers conferred on duly authorised officers by or under this Act"</i> .
Event A	The event created by communicator 1 in response to the first call at 11.07am.
Event B	The event created by communicator 2 in response to the second call at 11.30am.
Event C	The event created by communicator 3 in response to the third call at 12.19pm.
HBC	Henry Rongomau Bennett Centre – a mental health unit at Waikato Hospital.
MOU	Memorandum of Understanding
MSOPs	Master standard operating procedures (for Police Communications Centres)
NIA	Police database (National Intelligence Application)
NorthComms	Police Northern Communications Centre
Priority 1	Events in the CAD system are assigned a priority level. Priority 1 applies to situations involving: <ul style="list-style-type: none"> • actual threat to life/property happening now • violence being used/threatened • serious offence and offender present or leaving scene • serious vehicle crash • State Highway Event
Priority 2	Priority 2 applies to situations involving: <ul style="list-style-type: none"> • sudden death • evidence present (may be lost) • disorder • distressed victim • vehicle crash (not serious) • offender present (held not violent) • suspicious activity

Index of Police staff

Communications Centre Staff	Comment
Communicator 1	Answered the first call from the HBC nurse at 11.07am
Communicator 2	Answered the second call from the HBC nurse at 11.30am
Communicator 3	Answered the third call from Ms Y at 12.19pm
Dispatcher 1	Dispatched Officers A and B to locate Ms Morris at 11.10am. Mistook the information from the second call for a duplicate of the information from the first call, and subsequently did not dispatch officers to locate Ms Morris at Ms Y's address.
Dispatcher 2	On duty at 12.19pm, when the third call was answered by communicator 3 (Dispatcher 1 was on a meal break). Dispatched Police units, including Officers A and B, to locate Ms Morris at 12.25pm.

Field Staff	Roles/Comment
Officers A and B	Dispatched to locate Ms Morris at 11.13am. Checked Ms Morris's address from 11.16am – 11.23am and spoke to Mrs White. Dispatched to locate Ms Morris at 12.24pm. At around 12.40pm, Officer B discovered that Mrs White had been attacked in her home.
Sergeant on duty	The field sergeant.

Timeline of events on 19 January 2010

Time	Event/Comment
Approx 9.30am	Ms Morris threatened to kill her neighbour, Mrs White, during an assessment session at the Henry Rongomau Bennett Centre (HBC). Consequently the Psychiatric Registrar decided to formally detain Ms Morris under section 29(3) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
10.00am	Ms Morris left the HBC by climbing over a fence.
10.09am	An HBC nurse faxed a Missing Person's Report to the Hamilton Police watchhouse. Sometime later the HBC nurse attempted to telephone the Hamilton Police watchhouse to confirm that the fax had been received, but her call was not answered. The fax machine in the watchhouse was out of service from 10.05am until 10.57am, and the Missing Person's Report fax was not received until 11.04am.
11.07am	Having received no answer from the Hamilton Police, the HBC nurse called 111 and spoke to communicator 1 at the Police Northern Communications Centre (NorthComms). Communicator 1 created Event A and entered the information provided by the HBC nurse into the computer assisted dispatch (CAD) system.
11.10am	Dispatcher 1 notified Officers A and B that they would be dispatched to attend Event A, a "threat/intimidation" incident.
11.13am	Officers A and B advised that they were en route. Dispatcher 1 then gave the officers a description of Ms Morris, and advised that she had escaped from the HBC after threatening to kill her neighbour.
11.16am	Officers A and B arrived at Ms Morris's address. After checking Ms Morris's house they spoke to Mrs White and asked her to call the Police if she saw Ms Morris.
11.23am	Officer B advised NorthComms that there was no sign of Ms Morris at her address. The officers drove down the street in search of Ms Morris, then left the area.
11.30am	The HBC nurse made a second call to NorthComms to advise Police that Ms Morris was with Ms Y at a house near Ms Morris's (and Mrs White's) address. This call was handled by communicator 2 who, being unaware that one already existed, created a new event (Event B).
11.36am	Dispatcher 1 read the information associated with Event B. He believed it to be a duplicate of the information for Event A and did not read the text at the end of communicator 2's message which advised Ms Morris's current location. Consequently no Police officers were dispatched to Ms Y's address to apprehend Ms Morris.
12.19pm	Ms Y dialled 111 and informed communicator 3 that Ms Morris had been at her address from approximately 11.15am to 12.15pm and had just left. She said that Ms Morris had been acting strangely and was "after" Mrs White. Communicator 3 created an event with the information provided by Ms Y (Event C).
12.24pm	After being advised that Ms Morris had returned to Ms Y's address with blood on her face, communicator 3 upgraded Event C to Priority 1 (requiring an urgent response).
12.25pm	Dispatcher 2 sent officers (including Officers A and B) to locate Ms Morris.
12.40pm	Police discovered that Mrs White had been killed in her home, and located a bloodstained hammer at a nearby property.
12.52pm	Police took Ms Morris into custody.



Executive Summary

INDEPENDENT POLICE CONDUCT AUTHORITY

6. On the morning of Tuesday 19 January 2010, Police were notified by fax and telephone that Christine Judith Morris, a 40 year old patient at the Henry Rongomau Bennett Centre (HBC) in Hamilton, was missing. Ms Morris had climbed over a fence and left the HBC after threatening to kill her next-door neighbour, Diane Elizabeth White, aged 53.
7. At 11.13am two Police officers were dispatched to Ms Morris's address. They were unable to locate Ms Morris, but spoke briefly with Mrs White, as she mowed her lawn, and advised her to call Police immediately if Ms Morris arrived. The officers then left the area.
8. Shortly afterwards, at 11.30am, Police received a second call from the HBC advising that Ms Y, who lived near Ms Morris, had reported that Ms Morris was with her and was making threats to harm Mrs White. A Police Northern Communications Centre (NorthComms) dispatcher mistook the information from this call as a repeat of the information from the first call, and subsequently no officers were dispatched to Ms Y's address to apprehend Ms Morris.
9. At 12.19pm Ms Y made a call to Police advising that Ms Morris had just left her address. After a few minutes Ms Y reported that Ms Morris had returned with blood on her face. Officers were again dispatched to locate Ms Morris. They discovered that Mrs White had been attacked and killed in her home, and found a bloodstained hammer nearby.
10. Police quickly located Ms Morris and took her into custody. She later pleaded guilty to the murder of Mrs White, and on 2 April 2012 was sentenced to life imprisonment with a minimum non-parole period of ten years.
11. The Authority's investigation has considered whether Police complied with relevant law and policy during this incident, specifically in relation to the initial missing person notification; the handling, by NorthComms, of each of the three calls; and the Police response to the first and third calls.
12. The Authority has also examined whether current arrangements between Police and the Ministry of Health in respect of missing mental health patients are satisfactory.

Authority Conclusions

13. Police had the information and the ability to prevent the death of Mrs White. Had Police responded appropriately to the available information Mrs White's death could have been prevented.
14. The key Police failure in this case was that officers were not dispatched to apprehend Ms Morris at Ms Y's address after the second call from the HBC nurse. If that had occurred, it is likely that Mrs White's death would have been prevented.
15. The Police response to this incident was inadequate in a number of other respects:
 - the failure to respond to the initial fax notification and the follow-up phone call from the HBC nurse;
 - communicator 1's lack of questioning during the first call (regarding the threat and Ms Morris's mental state and hearing disability);
 - in relation to the first call, dispatcher 1's failure to advise Officers A and B of the name of the person being threatened, and his failure to notify the sergeant on duty and all units in the area about the threat posed by Ms Morris;
 - inadequate area enquiries by Officers A and B in response to the first call and their failure to seek more information about the identity of the person under threat;
 - communicator 2's poor handling of the second call – including a lack of questioning and the recording of inaccurate and misleading information in Event B;
 - in relation to the second call, dispatcher 1's failure to read the key piece of information in Event B, and his subsequent failure to dispatch officers to apprehend Ms Morris; and the Police's failure to consult a DAO about the situation with Ms Morris; and
 - the failure to consult a DAO, particularly when Ms Morris's location became known.

Section 27 opinion

16. Section 27(1) of the Independent Police Conduct Authority Act 1988 (the Act), requires the Authority to form an opinion as to whether or not any act, omission, conduct, policy, practice or procedure the subject-matter of an investigation was contrary to law, unreasonable, unjustified, unfair or undesirable.
17. Having regard to the factors in paragraphs 257 and 258, in terms of section 27(1) of the Act, the Authority has formed the opinion that the following matters were unreasonable and unjustified:

- i) the failure of Officers A and B to conduct more extensive enquiries; and
 - ii) communicator 2's poor handling of the second call to Police.
18. Having regard to the factors in paragraphs 257 and 258, in terms of section 27(1) of the Act, the Authority has formed the opinion that the following matters were undesirable:
- i) the Police's failure to respond to the initial fax notification and follow-up call from the HBC;
 - ii) communicator 1's inadequate handling of the first call to Police;
 - iii) dispatcher 1's inadequate response to the first call to Police; and
 - iv) dispatcher 1's failure to read the key piece of information in Event B, and his subsequent failure to dispatch officers to apprehend Ms Morris; and the Police's failure to consult a DAO about the situation with Ms Morris.

Section 27(2) recommendations

19. In the course of its investigation, the Authority has considered whether the officers and communications centre staff involved in this matter should have been the subject of disciplinary action. Police have advised that they have taken remedial action in connection with several staff. In view of the very clear findings contained in this report, the Authority confines itself to noting the action taken by Police.
20. The Authority notes that Police have taken action since 19 January 2010 to improve:
- the arrangements between Police and the Ministry of Health by clarifying each agency's responsibilities when a mental health patient is reported missing;
 - Police policy in respect of *People with mental impairments*; and
 - the training and performance of communicators and dispatchers in all Communications Centres.
21. The Authority supports the recommendations made in the Police review of their response to people with mental impairment. In particular, the Authority supports further training to all staff (front-line and communication centres) on Police legal powers and the *People with Mental Impairments* policy. The Authority also supports the continued roll-out of the Crime Reporting Line (CRL) to all Police districts.
22. Pursuant to section 27(2) of the Act, the Authority recommends that the New Zealand Police use the CRL for the notification to Police of missing, or absent without leave, mental health patients.



Background

INDEPENDENT POLICE CONDUCT AUTHORITY

SUMMARY OF EVENTS

Christine Judith Morris

23. Christine Morris is profoundly deaf and has a serious mental health illness. In January 2010 she was the subject of a community treatment order (see paragraphs 124-125).
24. Ms Morris lived next-door to Diane White, who had lived at her home in Hamilton for about 20 years. The two women had a difficult relationship and disputes had arisen over various matters. As recently as 7 January 2010, Police had been called to attend an argument between them and issued warnings to both women.
25. On 13 January 2010, Ms Morris's young child was taken into Child, Youth and Family (CYF) care. Ms Morris believed, mistakenly, that Mrs White was involved in the child being removed.
26. On 15 January 2010, Ms Morris voluntarily admitted herself to the Henry Rongomau Bennett Centre (HBC).

Events of 19 January 2010

27. At about 9.30am on Tuesday 19 January 2010, Ms Morris attended an assessment meeting at the HBC with her community support worker, an HBC nurse, and a Psychiatric Registrar. During the meeting, Ms Morris used sign language to communicate with her community support worker; who then translated the sign into spoken English for the others at the meeting. During the meeting Ms Morris communicated that she wanted to be discharged from the HBC, and she threatened to kill Mrs White.
28. The Psychiatric Registrar decided to change Ms Morris's status as a voluntary patient at the HBC to being the subject of compulsory detention under section 29(3) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (see paragraph 125).

29. When she was told of this, Ms Morris became upset and agitated. The Psychiatric Registrar suggested that she be given a sedative and a cigarette while he was preparing the paperwork needed to change Ms Morris's status.
30. Ms Morris was allowed to go outside under supervision but before she could be given the sedative she took the opportunity to climb a fence and leave. Because her status as a voluntary patient had not yet been officially changed, HBC staff believed they could not legally restrain her. The "*Mental Health (Compulsory Assessment and Treatment) Act 1992 section 29(3)(a) & (b)*" form needed to change Ms Morris's status was completed and signed only after she had already left the HBC.

Status of Ms Morris

31. Ms Morris's status under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) when she climbed the fence and walked away from the HBC is unclear. See paragraphs 28-30, 124 and 125 for an explanation of voluntary patients, community treatment orders and inpatients. However, what is clear is that both the HBC and Police treated Ms Morris as having 'escaped'; and the events that followed were predicated on that.

Fax notification

32. At 10.09am, in accordance with agreed protocols at the time, the HBC nurse faxed a three-page New Zealand Police Missing Person's Report to the Hamilton Police Station watchhouse. The fax number used by the nurse was the designated and dedicated fax number for the HBC to use. This report advised that Ms Morris was profoundly deaf; suffered from a mental disorder; was well known to mental health services and Police; had threatened to kill her neighbour; had been denied a discharge from the HBC; had become upset and agitated and jumped the fence at 10.00am; and was probably heading to her home (about four kilometres from the HBC).
33. This fax from the HBC was not received by Police until 11.04am, because the fax machine in the Hamilton Police Station watchhouse was being repaired and was out of service from 10.05am until 10.57am. Messages sent to the fax during this time were not diverted.

Sighting of Ms Morris

34. Shortly after Ms Morris had left the HBC, her community support worker drove past her walking along the street in the direction of her home. The community support worker later said she did not stop to talk to Ms Morris because: "*... she was aggressive and it had gone out of my hands. By this time I felt like it would have been unprofessional to assist at this stage.*" She immediately phoned the HBC and told the nurse who had attended the assessment meeting that she had seen Ms Morris on the street.

First call and dispatch

35. The HBC nurse followed up the fax notification with a telephone call to the Hamilton Police Station watchhouse in accordance with agreed protocols. After waiting some time for the call to be answered and receiving no response, she called 111 at around 11.07am and spoke to communicator 1 at the Police Northern Communications Centre (NorthComms).
36. The HBC nurse told communicator 1 that she was calling to report a person who was threatening to kill her neighbour. Communicator 1 began questioning the HBC nurse and obtained the following information:
- Ms Morris's name and address;
 - that during an interview she had threatened to kill her next-door neighbour, "Diane";
 - that she had escaped from the HBC after being denied a discharge;
 - that she had jumped the fence sometime between 10.00am and 10.30am;
 - the HBC nurse's name and contact details;
 - that Ms Morris was profoundly deaf;
 - that the HBC nurse had faxed through a Missing Person's Report to the Hamilton Police and had been trying to make contact by telephone without success; and
 - Ms Morris's date of birth and physical description.
37. The HBC nurse did not tell communicator 1 that Ms Morris's community support worker had seen her walking in the direction of her home.
38. While communicator 1 was speaking with the HBC nurse, he created an event (Event A) in the NorthComms computer-assisted dispatch (CAD) system with the headline "PATIENT THREATENED TO KILL THEIR NEIGHBOUR AND DECAMPED". The location of Event A was logged as Ms Morris's home address,¹ and the event was coded as "Intimidation/Threats" and assigned Priority 2.
39. When interviewed by the Authority, communicator 1 said that he considered the event to be Priority 2 rather than Priority 1 because of the time delay (Ms Morris had left the HBC

¹ NorthComms has Caller Line Identification (CLI), which automatically records the location of the address the call is being received from and enters it into the event. That address is logged as the event location unless it is immediately changed by the communicator. In this case communicator 1 changed the event location from the HBC to Ms Morris's address, because that was where Police would be sent to look for her.

up to an hour before the 111 call) and the fact that her location was uncertain. He explained that if Ms Morris had only just jumped the fence, or if her exact location was known, he would have made it a Priority 1 event. In this case officers were dispatched to Ms Morris's address within a matter of minutes, so the assigned priority did not affect the outcome (see paragraphs 167-172).

40. In the text for Event A, communicator 1 recorded the circumstances of the threat and Ms Morris's description. When asked which neighbour was at risk, the HBC nurse only knew Mrs White's first name – Diane. All of this information was entered into the CAD system and sent to dispatcher 1.
41. Communicator 1 later said it was quite difficult to assess the seriousness of Ms Morris's threat to kill Mrs White, because it was "*second-hand*" information which came from the HBC nurse (rather than Ms Morris herself). However he stated that he treats all calls of this nature seriously, as if the person intends to carry out their threat. He also stated that he deals with many calls about people absconding from mental health facilities, and from his experience a lot of the people who have absconded simply return to the facility later in the day.
42. Although the HBC nurse had mentioned that Ms Morris was profoundly deaf, communicator 1 did not record that information. Communicator 1 did not question the HBC nurse in depth about Ms Morris's threat against her neighbour, her current mental state, or the best way for Police to approach her (in view of her profound deafness). The Authority's analysis of the handling of this call is found at paragraphs 162-173.
43. Dispatcher 1 read the information relating to Event A as it was entered into the CAD system. He carried out a check on the Police database (NIA) and found that Ms Morris had several alerts, including, "*Mental Illness*" and "*Mentally Disaffected Person*". This information was inserted into the text for Event A at 11.09:12am.
44. When a missing person is reported and there are concerns for safety, Police standard operating procedures require the dispatcher to send a patrol unit to the scene, broadcast a message about the missing person to all units in the search area, and advise the sergeant on duty (see paragraph 147 for policy). In this case, dispatcher 1 did dispatch a unit to the scene, but did not advise the sergeant or units in the area.
45. When interviewed by the Authority, dispatcher 1 said initially that, ideally, the sergeant and other units in the area would have been advised at some point – provided they were not too busy with other matters. He stated that it was recorded in the event text that there had been a broadcast to all units about Ms Morris, but he did not actually make such a broadcast (see paragraph 178).

46. However, dispatcher 1 told the Authority later that he did not believe the ‘missing persons’ standard operating procedures accurately covered an event of this nature. There were a number of different categories that could apply to the event, including: escape from a mental health facility, missing person with mental health issues, or threat to a member of the public. He said that he did not broadcast a message to all units or advise the sergeant on duty in this case because there was a specific destination where he could send a unit to look for Ms Morris (her home address):

“If the information [from the caller] indicates a particular place [the missing person] might go, a unit will be sent. If there is not a specific location, and no unit is tasked, that will be when we broadcast details to everyone because they could turn up anywhere. If there is a specific destination known and a unit is assigned, it’s assigned to them and they make the enquiries.

... The most appropriate way to respond in this case was to dispatch a unit in a prompt manner to go and check on that location.”

47. Dispatcher 1 also commented that:

“... it’s not an unusual occurrence to have a mental health patient walking out of a facility. It’s a very, very regular occurrence to have mental health patients escaping from mental health care and to have various levels of reporting of that and of expectations about what Police will do to find them. There is only so much Police can do to actively look for those people.”

48. At around 11.10am dispatcher 1 notified a Police patrol unit (Officers A and B) that they would be tasked with attending a “*threat/intimidation job*”. Officer A had seven months’ service, and Officer B was a Field Training Officer with over five years’ service.
49. At 11.12am the 111 call from the HBC nurse ended and communicator 1 finished entering the information relating to Event A. Before ending the call, communicator 1 asked the HBC nurse to call back if she became aware of any further information, but did not give her a reference number for Event A.²
50. At 11.13am Officers A and B advised dispatcher 1 that they were ready to attend the incident, and dispatcher 1 gave the officers Ms Morris’s address and a description of Ms Morris (including the NIA alerts). Dispatcher 1 told the officers: “... *this morning at 10.30 she has threatened to kill her neighbour when released. They then haven’t released her*

² If the HBC nurse had quoted a reference number for Event A when she made her second call to NorthComms, the communicator who answered would have known immediately that Event A existed (see paragraph 73).

but she has managed to escape Henry Bennett and is thought likely to be heading to her home address.” Although communicator 1 had recorded that the name of the neighbour at risk was Diane, dispatcher 1 did not convey that information to the officers.

51. When interviewed by the Authority, Officer A said that at the time he realised the threat made by Ms Morris “*was of a serious nature*” but he did not register the fact that it was a threat to kill. He said that on a scale of 1 – 10 (with 10 being the most serious) he would have rated the threat as a 6 or 7. This assessment was based on:

“... a gut feeling I had at the time. Before this I have attended jobs where people have escaped from HBC but the thing that put this one into its own category is the fact that I guess it was outside of the norm, i.e. it wasn't night time; there was not any drinking involved; just that she had escaped and she was threatening somebody so it was quite easy to see a motive for escaping.”

52. Officer B said he rated the threat as “*pretty low, probably a 1 or a 2*”. In an interview with the Authority he said:

“I was aware of there being a threat to someone in the vicinity but I wasn't aware of a threat to that specific person [i.e. Mrs White]. I don't remember if I registered it was [a threat] to kill but it was a physical threat to a neighbour. ... The name of the target was never passed on.”

53. Later in the interview he stated:

“I wasn't aware it was a threat to kill and certainly not to that specific neighbour.

... A lot of my perception [of the threat] would be cloaked in often getting escapes from the HBC. More often than not there isn't a threat or we find out they're not subject to [a compulsory detention] order.”

54. After receiving the message about Ms Morris from dispatcher 1 (at 11.13am), Officer B asked dispatcher 1 whether Ms Morris was in the HBC's custody and dispatcher 1 advised “*... she should be*” – which the officer understood to mean that he could arrest her.

55. Ms Morris was by now an “*inpatient*” in accordance with section 29(3) of the Mental Health Act. Section 32 of the Mental Health Act provides that an inpatient who is absent without leave may be “*retaken*” by any person and returned to hospital (see paragraphs 124-126).

56. Under section 109 of the Mental Health Act, Police may also apprehend any person they reasonably believe to be mentally disordered in a public place (see paragraph 128). This meant that Officers A and B were empowered to arrest Ms Morris and return her to the HBC if they found her on the street.

57. If the officers had located Ms Morris in a private residence, however, they would have needed authorisation from a duly authorised officer (DAO) before they could enter the house and arrest Ms Morris without a warrant – unless they were acting under sections 41 or 317 of the Crimes Act, which empower Police to enter a property and to use force in order to prevent the commission of a crime that would be likely to cause immediate and serious injury to any person (see paragraphs 127, 130-131, 136 and 148 below for discussion of the relevant law and Police policy).
58. The possible need for a DAO's involvement in the apprehension of Ms Morris was not discussed by the HBC nurse and communicator 1 (or communicator 2 in the second call, see paragraph 84 below). In this case, Ms Morris had made a threat to kill and the officers would have been legally justified under section 317 of the Crimes Act in entering a private address to arrest Ms Morris, provided they believed "*on reasonable and probable grounds*" that Ms Morris was about to seriously harm somebody. If that threshold was not met, however, then a DAO needed to be present as outlined in section 41 of the Mental Health Act and the Police guidelines (see paragraphs 229-235 for further discussion of this issue).
59. When interviewed by the Authority, Officer B said that:

"Because of the threat I would have arrested her under the Mental Health provisions. If it was an 'illegal' arrest, it would have been in good faith and I would have taken her back [to the HBC] under arrest under the Mental Health Act.

... If [Ms Morris] was found in the street, what you should do is you should involve a DAO when making the arrest but in practice it doesn't happen, they never come out. DAOs are just too busy so I would have taken her back to the HBC myself.

The Crimes Act never entered my mind because I was dubious if the threat was legitimate."

Police response to first call

60. Officers A and B advised dispatcher 1 that they had arrived at Ms Morris's address at 11.16:28am. Ms Morris and Mrs White lived in adjoining units (A and B), located up a driveway about 50 metres from the main road. There were another two units on the opposite side of the driveway.



61. Upon their arrival the officers spoke to a neighbour who was walking down the driveway towards the main road. He said he had not seen anyone at Ms Morris's address for a few days (Ms Morris had been at the HBC since 15 January 2010). The officers told the neighbour that Ms Morris had escaped from the HBC, and asked him to call the Police if he saw her.
62. After checking Ms Morris's address and finding no one there, the officers spoke to Mrs White outside her house. She said she had not seen Ms Morris for about five days. The officers explained that Ms Morris had escaped from the HBC, and advised Mrs White to be careful and not to approach Ms Morris. They also asked her to call Police immediately if Ms Morris came home.
63. When interviewed by the Authority, Officer B could not recall exactly what he told Mrs White but said: *"I believe I would have made a comment about threats because it is clear ... that the dispatcher said threats had been made."* However he did not know at the time that Mrs White was the target of the threats, and there was nothing to suggest to him from their conversation that she was the target. Officer B said that Mrs White appeared to be unconcerned that Ms Morris had escaped and *"didn't express any indication she even knew her that well."*
64. Officer A said:
- "I distinctly recall saying [Ms Morris] is out threatening one of her neighbours. The reason I recall that is as I told [Mrs White], she had this sort of blasé look on her face as if [to say] 'oh yeah here we go again'. I didn't think she really understood the importance of the situation, probably because I didn't say she was threatening to kill somebody. ... I do remember telling her [Ms Morris] had escaped, but I didn't realise [the threat] was directed towards [Mrs White]."*

65. The officers had not been told the name of the neighbour at risk, and did not seek that information from NorthComms. When asked whether they considered contacting NorthComms for more information, Officer A said: *“To be honest, no, and I think that comes down to my inexperience at the time because I had not been an officer for very long.”* Officer B said it did not occur to him to seek more information at the time. He also saw no reason to consult the sergeant on duty about the incident. He stated:

“We hadn’t been told [Ms Morris] was going to that address, only that she might be going there. I had no good reason to believe she was even in the area but I wanted to make sure she wasn’t.

We were also in the middle of a couple of domestics. I’m not saying we shortcut this job because we didn’t but we had other pressures on that day as well. It was purely a door knock to see if [Ms Morris] was there.”

66. The officers did not see anybody outside the two units on the opposite side of the driveway, and did not speak to any other neighbours. A brief street patrol produced no sightings of Ms Morris.
67. It appears that around this time Ms Morris was at her neighbour, Ms Y’s, house on the main road two properties away from the driveway that led to Ms Morris and Mrs White’s units. Ms Y’s house was not visited by the officers.
68. At 11.22:43am, about six and a half minutes after they had arrived, Officer B advised NorthComms:

“Yeah, no joy here. We’ve spoken to two neighbours. They say no one’s been at the property between 4 and 5 days. No evidence found there. Both neighbours have been instructed to give us a call if they see her.”

69. The officers then returned to the Police station to deal with other matters. For the Authority’s findings on the officers’ response to this incident, see paragraphs 181-192.
70. Dispatcher 1 noted the officers’ report in the CAD system and *“dispatch assigned”* the event to Officers A and B, meaning that it would remain open pending any further developments. He did not take any further action to locate Ms Morris, such as advising patrol units in the area to be on the lookout for her, or notifying the sergeant. For the Authority’s findings on dispatcher 1’s handling of this call, see paragraphs 174-180.

Second call

71. Meanwhile, Ms Y had called the HBC to tell them that Ms Morris was at her house. The HBC nurse agreed to advise Police that Ms Morris was at Ms Y’s address and to ask them to return Ms Morris to the HBC.

72. Although Ms Morris's location was now known, the HBC did not arrange (in consultation with Police) for a DAO to be sent to Ms Y's address to meet with Ms Morris and transport her back to the HBC.
73. At about 11.30am the HBC nurse made a second call to NorthComms, this time on the general line, and spoke to communicator 2. She said that she had been put through to NorthComms to "report about our missing person". Communicator 2 created a new event in the CAD system (Event B), being unaware that Event A, entered by communicator 1 from the first call, already existed.
74. The CAD system has a 'nearby event warning' feature, which alerts communicators to existing events that are within 500 metres of a new event's location. If the event location for Event B had been recorded as Ms Morris's or Ms Y's address, the nearby event warning would have alerted communicator 2 to the presence of Event A, and given her the option of adding text to that event.
75. In this case the feature did not operate because the location for Event B was automatically recorded and verified as the HBC (i.e. the place where the call was made). Communicator 2 later changed the event location and saw that Event A existed (see paragraphs 79-80), but she decided to complete entering Event B rather than updating Event A. This is discussed further in paragraphs 195 and 207-208.
76. On the understanding that the HBC nurse was calling to report a missing person, communicator 2 entered the headline for Event B as "MORRIS/CHRISTINE GONE AWOL". The event was coded as "Missing Person" and assigned Priority 2.
77. Communicator 2 said later, when asked why she considered the event to be Priority 2 rather than Priority 1:

"Based on this call it was not a P1 [i.e. Priority 1]. A P1 for me is if I was talking to the person who was watching [Ms Morris] and she was threatening or had a weapon at the time - that would be a P1. This was a second hand informant as such P1 is something happening right there and then and the person calling is witnessing it. This was second hand from someone who couldn't tell me any more than what they heard from someone else."

78. Communicator 2 began questioning the HBC nurse about how Ms Morris had gone missing from the HBC. The HBC nurse attempted to say that she had received a call from Ms Y, and knew Ms Morris's current location, but communicator 2 was focused on her line of questioning and did not absorb that information. About one and a half minutes into the call, the HBC nurse told communicator 2 that Ms Morris had threatened to "kill" her neighbour – however communicator 2 recorded that Ms Morris had threatened to "harm" her neighbour.

79. Approximately two minutes into the conversation, communicator 2 realised that the HBC nurse was calling to tell Police that Ms Morris was at Ms Y's address. At this point communicator 2 changed the location for Event B from the HBC to Ms Y's address. However the headline and code for the event remained the same, giving the impression that Event B was a report that a person was missing, rather than a report that a missing person's location was known and there was a threat to kill.
80. When she changed the location for Event B, communicator 2 saw Event A in the CAD system. She did not check that event thoroughly, and did not consider updating it with the new information (that Ms Morris was at Ms Y's house); instead she carried on completing Event B.
81. Communicator 2 obtained a description of Ms Morris from the HBC nurse, and clarified that Ms Y was not the neighbour that Ms Morris had been threatening to kill. The HBC nurse provided her with an address for the neighbour at risk (i.e. Mrs White), and then said:
- "... the neighbour that she's with [i.e. Ms Y] is okay, she's not threatened in any way but she's rung because Christine's upset at the moment. We're thinking she might not act out but we just have to take precautions."*
82. At the end of the text she had entered into the CAD system for Event B, communicator 2 entered the information that Ms Morris was currently at Ms Y's address. The call ended at 11.35:06am.
83. Communicator 2 later said that she did not consider upgrading the priority level of the incident when she learned that Ms Morris was at Ms Y's house. In an interview with the Authority she stated: *"... even though [Ms Morris was] in close proximity [to the person she had threatened] for me it still didn't warrant it being a P1."* When asked to rate her perception of the seriousness of the threat from Ms Morris on a scale of 1-10 (with 10 being the most serious), communicator 2 said:
- "... in the middle about a 5 wouldn't be any more. I judged it on the fact the call had been checked because I had already read the other job [Event A]. To me it was just an update call from the nurse about the same job. Just another threat from HBC."*
84. As with the first call, the HBC nurse had mentioned that Ms Morris was profoundly deaf but this information was not recorded by communicator 2 and thus was not passed on to the dispatcher. Communicator 2 did not question the HBC nurse in depth about Ms Morris's hearing disability or mental state, and did not ask for the name of the neighbour who had been threatened. In addition, communicator 2 did not discuss the possible need for a DAO to be involved when Police went to apprehend Ms Morris and return her to the

HBC (see paragraphs 58 and 229-235). For the Authority's findings on communicator 2's handling of this call, see paragraphs 194-212.

85. Dispatcher 1 read the information associated with Event B as it was entered into the CAD system. He was sitting near communicator 2 and discussed Event B with her briefly at the beginning of the call, before she had been told that Ms Morris was at Ms Y's house. He told her that he knew about the incident and that Police had checked Ms Morris's address. He formed the opinion that the HBC was calling to ensure that NorthComms had received the information that Ms Morris was missing and that Police were taking some action.
86. Communicator 2 did not tell dispatcher 1 that Ms Morris had been located near her home. As most of the information recorded for Event B was similar to the information recorded for Event A, dispatcher 1 thought that Event B was just another report about Ms Morris being missing, and that there was no additional information that required further action.
87. Dispatcher 1 did not read the text at the end of Event B, which indicated that Ms Morris could be found at Ms Y's address, and did not realise that communicator 2 had changed the event location from the HBC to Ms Y's address. He did not recognise the change in situation (despite indications in the CAD system that new information had been added to Event B – see paragraph 119), and therefore did not dispatch officers to Ms Y's address.
88. At 11.35:19am dispatcher 1 entered text into Event B indicating that Police had already checked Ms Morris's address but had not been able to locate her.
89. Dispatcher 1, in the belief that Event B was the same as Event A, cross-referenced the two events. Event A had already been dealt with by Officers A and B (see paragraphs 48-69). For the Authority's findings on dispatcher 1's handling of this call, see paragraphs 213-218.

Third call and dispatch

90. Sometime after Ms Y called the HBC to report that Ms Morris was at her house, she phoned the HBC again. She was told that the Police had been sent to her address, but that she should call the Police herself since they had not yet arrived. Ms Y was reluctant to do this while Ms Morris, whom she knew from previous contact as a neighbour, was still in the house and behaving strangely. Therefore she waited until Ms Morris left before calling NorthComms.
91. At 12.19pm (about 50 minutes after the second call to NorthComms from the HBC nurse), Ms Y rang 111 and spoke to communicator 3, saying that she was calling about an "escaped Henry Bennett patient". The information from this call was recorded by communicator 3 in the CAD system as Event C, which was coded as "Mental [Health]" and

- labelled Priority 2. The headline was: “*INFMT [informant] FOUND ABSCONDED 1M [mental health patient]*”, and the event location was logged as Ms Morris’s address.
92. Ms Y informed communicator 3 that Ms Morris had been at her house for the previous hour and had left about five minutes ago. She said she had notified the HBC that Ms Morris was with her, but had been told to call the Police directly.
 93. Communicator 3 gathered basic details from Ms Y – her name and address, what time Ms Morris had left her house and in which direction she was travelling, and a description of Ms Morris. Ms Y told communicator 3 that Ms Morris was “*after*” her neighbour, and had written this down – part of her normal way of conversing due to her profound deafness.
 94. Ms Y told communicator 3 that after Ms Morris had left her house, she saw her go to the next-door neighbour’s house, knock on the window, and then walk away.
 95. When interviewed later, Ms Y’s next-door neighbour said that Ms Morris had knocked on his window and asked to borrow his hammer, which he had given to her.
 96. Meanwhile, at NorthComms, dispatcher 2 had taken over from dispatcher 1 who was having a lunch break. At 12.20:06pm, dispatcher 2 acknowledged receipt of Event C in the CAD system.
 97. A few minutes later, while Ms Y was still on the telephone with communicator 3, Ms Morris returned to Ms Y’s address with blood on her face. Ms Y relayed this to communicator 3, and said that she could see a bloodstained hammer on her next-door neighbour’s doorstep.
 98. In response to this information, communicator 3 upgraded Event C from Priority 2 to Priority 1 at 12.23:53pm. Dispatcher 2 then notified the sergeant on duty and reported that Ms Morris had been seen with blood on her face.
 99. Officers A and B heard this radio transmission and contacted the dispatcher to say they had attended an incident involving Ms Morris earlier that day when she had “*made threats to kill her neighbours*”. They offered to attend the scene and dispatcher 2 agreed. Over the next few minutes dispatcher 2 organised four other units (in addition to the sergeant and Officers A and B) to go to the area in search of Ms Morris.
 100. Dispatcher 1 returned from his lunch break and saw Event C on the CAD system. He had a brief discussion with dispatcher 2 and told her to continue dispatching the job while he notified their supervisor about the incident. None of the NorthComms staff involved (communicators or dispatchers) had consulted the supervisor earlier because they had not considered it necessary.

101. Ms Y provided live updates about Ms Morris's movements until she had walked away from her house and out of sight. Communicator 3 asked dispatcher 1 whether she should keep Ms Y on the line, and was told "Negative". Communicator 3 then gave Ms Y the reference number for Event C, and asked her to call 111 again if Ms Morris came back. The call ended at 12.34pm.
102. For the Authority's findings on the handling of this call, see paragraphs 219-224.

Police response to third call

103. Officers A and B arrived in the vicinity of Ms Morris's address shortly after the 111 call had ended. They were unable to locate Ms Morris in the street, and so headed to her home to look for her.
104. After checking Ms Morris's house without success, they went to Mrs White's property and, at around 12.40pm, discovered that Mrs White had been attacked. An ambulance was called but Mrs White died at the scene from multiple head injuries.
105. At 12.52pm officers located Ms Morris in a nearby street and took her into custody. She was later charged with the murder of Mrs White.
106. For the Authority's findings on the Police response to the third call, see paragraphs 225-228.

SENTENCING OF MS MORRIS

107. Ms Morris pleaded guilty to the murder charge and, on 2 April 2012, was sentenced to life imprisonment with a minimum non-parole period of 10 years. Justice Andrews directed that Ms Morris be detained in a hospital as a special patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992, pursuant to section 34(1)(a)(i) of the Criminal Procedure (Mentally Impaired Persons) Act 2003.

POLICE INVESTIGATION

Policy, practice and procedure review

108. On 19 January 2011, Police reported on a Policy, Practice and Procedure review of this incident. Some of the key findings of the review were:

"Key Finding (1)

That [Event B] was cross-referenced with [Event A] by the NorthComms Dispatcher [i.e. dispatcher 1] without the Dispatcher having read all the comments and details associated with [Event B]. This resulted in a

failure to dispatch a Police patrol to the address where MORRIS was, which most likely would have resulted in MORRIS being apprehended prior to the homicide. ...

Key Finding (2)

[Communicator 2] did not establish from the start of the call exactly what the caller was calling about. She had made an assumption based on what was initially said by the caller and subsequently used “closed questioning” instead of open-ended questions. ...

Key Finding (3)

There is a lack of on-going formal training for Communicators, as well as a lack of research in the area of call handling techniques. ...

Key Finding (4)

Due to the supervisor’s span of control and other duties, along with the volume of calls taken and Events dispatched, there was limited oversight by a supervisor of the Communicator and / or Dispatcher and therefore no quality control over how both were performing. ...

Key Finding (5)

Neither the Memorandum of Understanding between Police and Ministry of Health or the Police Manual makes reference to Mental Health Patients who have absconded or are missing. ...”

109. The Police review concluded that the homicide of Diane White was “preventable” for a number of reasons, and that, in relation to Police actions:

“... if the NorthComms Dispatcher [i.e. dispatcher 1] had read the full contents of [Event B], and a Police Patrol [had been] sent to the location where MORRIS was reported to be at the time, she would have been located prior to the homicide.”

110. The review went on to say: *“In saying that there is no actual or potential criminal liability. No person was acting under a ‘duty’ in terms of the Criminal Law, and under common law there needs to have been ‘gross negligence’ and these actions do not amount to that.”*
111. A number of recommendations were made in the Police review. See the **Subsequent Police Action** section of this report for further detail.

Communications review

112. A Police Communications expert prepared an analysis of the actions of the NorthComms staff, which formed part of the overall Police review. In his report (dated 9 February 2010) he stated:

“Errors were made by both communicators and the dispatcher involved in this matter. Some errors were directly related to the death of Mrs White, while others had the potential for disaster if circumstance had followed a slightly different course.

However as to accountability for the errors we must look further than the individuals involved. None of the individuals were acting outside the norms established within the communications centres by the centre management. They were conducting business as usual in the manner that was expected of them. The standards displayed in this case have been accepted as satisfactory for a long time.

...

The errors noted in the current investigation are not unique. They occur every day in all communications centres. The only unusual feature of this case is that all the errors lined up and created an unbroken chain which resulted in a death.”

Analysis of Call 1

113. The Police Communications expert’s assessment of communicator 1’s handling of the first call to NorthComms, benchmarked against the relevant standard operating procedures and related best practice, concluded that communicator 1 had failed to use open questions and to pursue some important lines of inquiry during the call. In his report he stated:

“The overall assessment of this call was that the basic matters were covered adequately, however the unique nature of this situation – mental health issues, hearing disability, threats to kill all combined in a single subject did not trigger the level of questioning required. The communicator was too eager to record the basic details quickly and failed to allow time to assess the overall situation and consider what additional critical information that was required.

In short, a simple “Tell me about it” early in the call would have allowed the caller to explain the position from her perspective without interruption and given the communicator an opportunity to listen and formulate effective questions.”

114. A separate review by the National Operations Manager: Police Communications Centres noted that caller behaviour may have impacted on the lack of further questioning by communicator 1; but when interviewed by the Authority, communicator 1 said that caller behaviour did not influence the way he handled the call.

Analysis of Call 2

115. In relation to communicator 2's handling of the second call to NorthComms, the Police Communications expert concluded:

"The communicator made a premature and wrong evaluation of the call and by exclusive use of closed and narrowly focused questions failed to provide any opportunity for corrective action to be taken until the end of the call. Having identified the revised situation, she made no effort to rectify the situation by exploring the critical issues that needed to be dealt with.

This was a classic example of what is called "300 call syndrome" where a communicator becomes so de-sensitised to calls of a particular type that are received frequently (in this case people who have absconded from institutions) that they make an initial assessment as to the type of call based on the first few words, and then become convinced that they understand the situation based on a previous experience. Once they are convinced they understand the situation they target their questions based on their own assessment rather than the information provided by the caller."

116. In respect of the creation of Event B, the Police Communications expert found that:

"The way this event is structured makes it clear that the majority of it was written before the communicator had established the true situation.

In this case it would have been better to create a new event structured correctly and to cancel the faulty event. This would have initiated the 'nearby event' warning on verification and allowed for merging the new event into the existing original event. This would have ensured that the critical information [where Ms Morris could be located] was not buried among a mass of duplicate data."

117. The National Operations Manager: Police Communications Centres noted that: *"although there could have been better questioning by [communicator 2], she obtained the relevant information and followed correct procedure as it became apparent in the call."*

118. In relation to dispatcher 1's actions following the second call to NorthComms from the HBC nurse, the Police Communications expert said:

"There is no evidence to suggest that [dispatcher 1] was in any way negligent in his duties. In the period leading up to this incident he displayed considerable diligence and professionalism in his work.

It is clear that he missed the key piece of information, and it is necessary to consider possible causes.

Analysis of the event chronology and audio of the phone calls reveals serious deficiencies in the call handling and questioning techniques employed by the two communicators [i.e. communicators 1 and 2] who were involved with the events handled by [dispatcher 1].

In particular, the second call was incorrectly categorised and poor question technique failed to identify the problem until late in the call. The critical information was not entered until the last few lines.

The way in which this call was handled resulted in a number of safety measures being circumvented and the dispatcher being presented with an event which failed to clearly identify the issue.

I believe that the format of the event text was a major cause of the mistake made by [dispatcher 1]."

119. However the review conducted by the National Operations Manager: Police Communications Centres noted that when communicator 2 changed the event location for Event B:

- the new information would have been presented in blue text on the screen indicating that it was new;
- a large button on the dispatcher's screen titled *"Displayed – Remark"* would have turned red to indicate that the event had been updated with new information; and
- *"The location of the flag on the mapping screen would have shifted from the Henry Bennett Centre to [Ms Y's address]. This would have placed it in close proximity to the original flag at [Ms Morris's address] and would have, dependent on the magnification of the map set up on the dispatch screen, by shown as either two flags side by side or alternatively indicating two events in that area."*

120. He concluded that the information that Ms Morris was at Ms Y's address *"was there to be seen by the Dispatcher who missed the three changes on the dispatch screen advising him of the pertinent information."*

121. In an interview with the Authority, dispatcher 1 said that:

- He could not recall whether new information was presented in blue text at the time of this incident, because the CAD system has changed a number of times since then.
- The *“Displayed – Remark”* button turned red whenever anything was typed into the event, including information entered by him.
- He would generally *“only be looking at the map field on an initial reading of the job in order to send a unit there or if actively positioning cordons or something else. From then on you don’t have time to look over to the map screen.”*

122. Dispatcher 1 explained that the CAD system has been upgraded since January 2010:

“The current system is ... simplified so we don’t have to actively seek updates any more, they are coming through automatically. In my opinion the current system has it about right. Under the older system by contrast you actively had to update a number of things and that’s difficult if you’re busy.”

123. When asked whether updates to an event could still be missed by NorthComms staff, he said: *“I believe it would be much harder to miss them but it depends on the ‘busyness’ at the time ... everyone does their job the best they can.”*



Applicable Laws and Policies

INDEPENDENT POLICE CONDUCT AUTHORITY

MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992

124. Under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act), the court may make a compulsory treatment order relating to a person who, following assessment, is found to be “*mentally disordered*”. Compulsory treatment orders are either:

- “*inpatient orders*” – where the person is required to be continually detained at a hospital for treatment; or
- “*community treatment orders*” – where the person is given treatment as an outpatient.

125. Section 29 of the Mental Health Act, which relates to community treatment orders, provides:

“(1) *A community treatment order shall require the patient to attend at the patient's place of residence, or at some other place specified in the order, for treatment by employees of the specified service, and to accept that treatment.*

...

(3) *If, at any time during the currency of the community treatment order, the responsible clinician considers that the patient cannot continue to be treated adequately as an outpatient, the responsible clinician may direct that the patient—*

- (a) *be treated as an inpatient for a period of up to 14 days;*
or
- (b) *be re-assessed in accordance with sections 13 and 14.”*

126. Under section 32 of the Mental Health Act, inpatients who are absent without leave from the hospital where they are receiving treatment may be “retaken” by any person within three months and returned to hospital.
127. Section 41 of the Mental Health Act states that a duly authorised officer (DAO) may call upon the Police for assistance in certain circumstances, including situations where a patient is absent without leave from the hospital they are required to attend. Under this section a constable who is called upon to assist a DAO is empowered to enter the premises where the patient is and transport him or her back to hospital. However they must not exercise this power without a warrant from a District Court Judge if it would be “reasonably practicable” to obtain one.
128. Under section 109(1) of the Mental Health Act, Police may take any person they find “wandering at large in any public place and acting in a manner that gives rise to a reasonable belief that he or she may be mentally disordered” to a Police station or hospital so that they may be examined by a medical practitioner as soon as practicable.
129. Section 122B of the Mental Health Act states that a person exercising a power under the Act to take or return a patient to hospital for treatment may, if they are exercising the power in an emergency, use “such force as is reasonably necessary in the circumstances”.

CRIMES ACT 1961

130. Under the Crimes Act 1961, Police have the power to enter a property and to use force in order to prevent the commission of a crime that would be likely to cause serious injury to any person.³ Section 317 (2) of the Crimes Act states:

“Any constable, and all persons whom he calls to his assistance, may enter on any premises, by force if necessary, to prevent the commission of any offence that would be likely to cause immediate and serious injury to any person or property, if he believes, on reasonable and probable grounds, that any such offence is about to be committed.”

131. Section 41 of the Crimes Act provides:

“Every one is justified in using such force as may be reasonably necessary in order to prevent the commission of suicide, or the

³ Section 14 of the Search and Surveillance Act 2012 (which came into force on 1 October 2012) provides that officers may enter a private property without a warrant if they have reasonable grounds to suspect that “an offence is being committed, or is about to be committed, that would be likely to cause injury to any person, or serious damage to, or serious loss of, any property”, or “there is risk to the life or safety of any person that requires an emergency response”.

commission of an offence which would be likely to cause immediate and serious injury to the person or property of any one, or in order to prevent any act being done which he believes, on reasonable grounds, would, if committed, amount to suicide or to any such offence [emphasis added].”

POLICE POLICIES

132. In January 2010, Police had a policy titled “*People with mental impairment*” which outlined the assessment and treatment procedures under the Mental Health Act 1992 for the general information of Police staff.
133. This policy also explained the powers that Police have when they are called upon to assist a DAO under section 41 of the Mental Health Act (see paragraphs 127-129), and set out the procedures for assisting a DAO. However the policy did not state what action should be taken when a mental health patient is reported as being absent without leave. Since this incident took place, the policy has been significantly amended; see the **Subsequent Police Action** section of this report for further detail.

MEMORANDA OF UNDERSTANDING

National level

134. On 6 March 1995, New Zealand Police and the Ministry of Health created a Memorandum of Understanding (MOU) to give guidance to Police staff and health professionals administering the provisions of the Mental Health (Compulsory Assessment and Treatment Act) 1992.
135. In January 2010 this national MOU formed the basis for agreements with Mental Health Services at Police region and district level, and was published on the New Zealand Police Intranet for the information of all staff. In December 2012 Police and the Ministry of Health signed a new national MOU that replaced the MOU that was in force during this incident (see the **Subsequent Police Action** section for further detail). The Authority has undertaken its investigation and makes its findings and recommendations based on the MOU that was in place at the time of this incident.
136. Some of the relevant points from the overarching national MOU in force at the time were:

“2.1 *The Duly Authorised Officer is the official in charge at any incident that requires the invoking of the Act and a combined Police/Mental Health Services response. In the absence of a Duly*

Authorised Officer.....the Registered Medical Practitioner is the official in charge.

- 2.2 *The [police] may be called upon to assist the health professionals but will continually review the appropriateness of the action requested of them. The police will advise the health professionals if the actions requested of them are outside their powers or immediate ability.*
- 2.3 *DAOs should only request police assistance when the particular powers and specific expertise of the police are required.*
- 3.1 *DAOs have the responsibility for arranging the transportation of patients, potential patients and patients absent without leave.*
...
- 3.4 *Where police have been called to assist a DAO or Registered Medical Practitioner, the DAO OR a suitable health professional will at all times PHYSICALLY accompany and monitor the patient or proposed patient. ...*
- 4.3 *If it is necessary to use force to take and/or detain a patient or proposed patient the DAO or Registered Medical Practitioner shall give a clear instruction to police to do so. Police officers must be certain of the section of the Act they are acting under that authorises the use of force before applying such force."*

137. The MOU was silent on the responsibilities of each party when responding to a patient's escape or absence without leave from a Mental Health Services facility.

Local level

138. An MOU entered into by the Waikato Police District and the Waikato District Health Board (Health Waikato – Mental Health & Addictions Services) was reviewed in April 2007. This MOU generally followed the national model but also contained the following:

"EXCHANGE OF INFORMATION

- 5.1 ...

Should the Police believe there is a serious and imminent threat existing requiring urgency, then the Police may liaise directly with Health Waikato Staff.

Nothing in legislation prohibits the exchange of information between the two agencies where it is either not desirable or not practicable to obtain authorisation from the individual concerned, and this is necessary to avoid prejudice to the

maintenance of the law by Police, or to prevent or lessen a serious and imminent threat to public health or safety, or to the life or health of any person.”

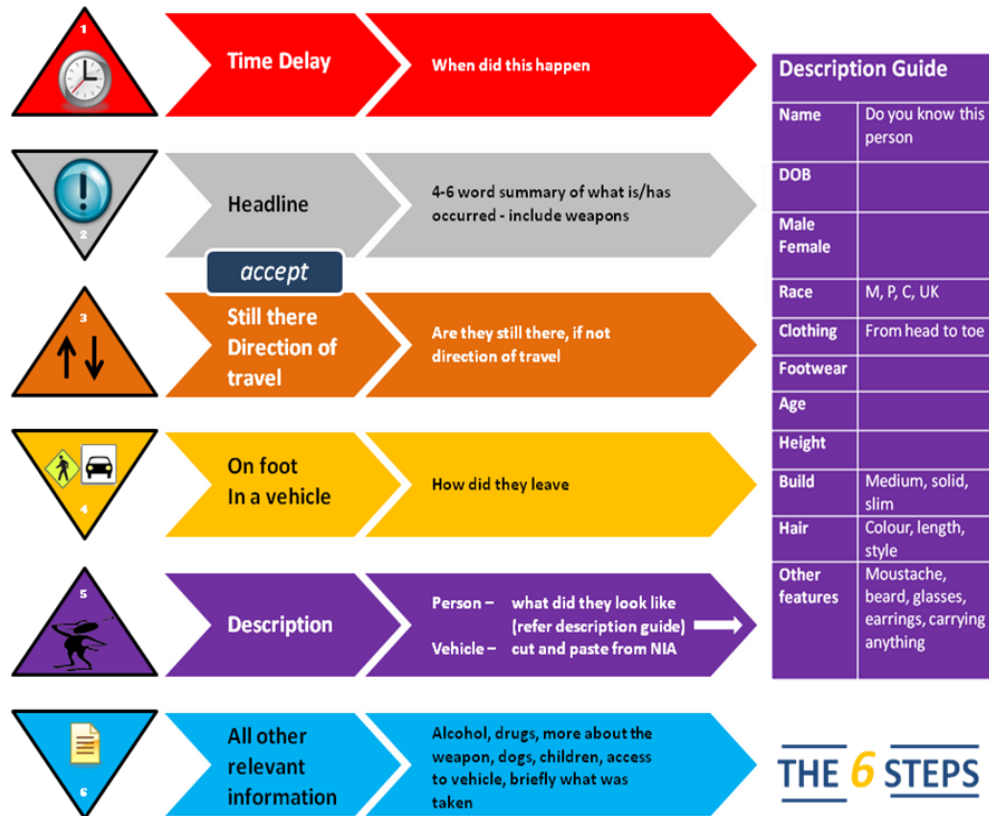
139. As with the national MOU, the Waikato Police/District Health Board MOU was silent on specific responsibilities for responding to a patient’s escape or absence without leave from a Mental Health Services facility.⁴

COMMUNICATIONS – STANDARD OPERATING PROCEDURES

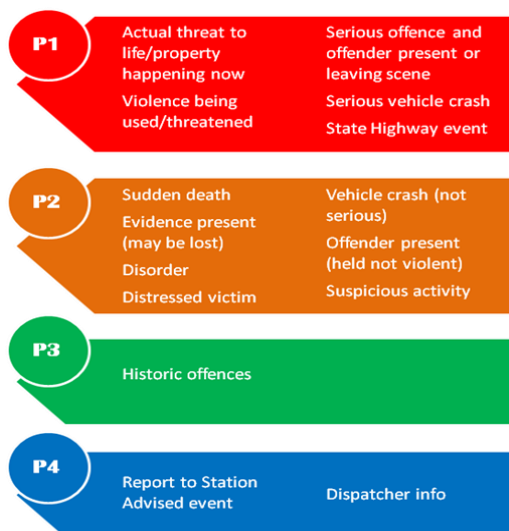
140. Calls to NorthComms are answered by communicators, who gather initial information and determine whether a Police response is required. If a response is required, a dispatcher allocates Police units to attend and also gathers and passes on any further relevant information to the field units. The communicators and dispatchers are overseen by a team leader.
141. In January 2010 there were a number of documents that set out the procedures to be followed by communicators and dispatchers in Police Communications Centres when receiving calls about people who are missing and/or mentally disordered, including:
- Communications Centres Administrative Standard Operating Procedures (ASOPs) – Call Taking instructions;
 - Communications Centres Master Standard Operating Procedures (MSOPs), including:
 - Communicator standard action – Missing Persons; and
 - Communicator standard action – Mental Health;
 - District Mobilisation Plan (DMP) Hamilton City – Mentally Disordered Persons; and
 - Communications Centre communicator and dispatcher training manuals.
142. When a 111 call is made to Police, communications centre communicators follow a six-step process to gather information. In summary, the six steps are: when the incident occurred; what happened (including whether weapons were involved); whether the offenders are still at the scene; how the offenders left; a description of the offenders; and any other relevant information (such as involvement of alcohol or drugs, presence of children or dogs, any further details about weapons, access to vehicles, and whether

⁴ Police have indicated to the Authority that following the signing of the new national MOU in December 2012 the local MOU’s will also be updated.

anything was taken). Call takers have the following chart to assist them in obtaining this information:



143. The communicator then assigns a priority level to the call, ranging from Priority 1 – for serious incidents including those where there is a threat to life or property, or violence being threatened or used – to Priority 4 for events that do not require a Police response.



144. The information entered by the communicator is immediately received on the screen of the communications centre dispatcher responsible for the area in which the incident is occurring.

145. Under the heading “Multiple Calls re: Single Events” in the ASOPs, the following instructions are to be followed by a communicator (call taker):

“If a Calltaker receives a call on an event that has already been entered, the Calltaker will update the existing event with the current information, provided the caller is the original informant.

If a call is received from a new caller but relating to an existing event in the system, a new event is to be created, the Dispatcher will merge events at a later stage”.

146. At the time of this incident, the MSOPs relating to events involving missing persons and/or mentally disordered persons required the communicator to ascertain the following “key” information:

Missing Persons	Mentally Disordered Persons
<ul style="list-style-type: none"> • fears for safety/reason for concern; • the person’s details (sex, age, race, clothing); • physical and mental condition; • whether on medication, and if so whether they are overdue; • particulars of next-of-kin; • where they are missing from, where last seen; • mode of transport/where headed; and • the caller’s details. 	<ul style="list-style-type: none"> • actions or behaviour causing concern; • details of any weapons; • reason why the caller believes the person is mentally disturbed; • current location (public place or private property); • can drugs and/or alcohol be discounted; • whether the person is placing him or herself in danger or likely to commit an offence / suicidal / jeopardising public safety; and • whether the person is alone or with another person.

147. The relevant MSOPs for the dispatcher stated that:

- for incidents involving mentally disordered persons:
 - a Police unit should be dispatched to attend the incident “where warranted by behaviour to take person to his or her residence ([or] to care of a responsible person)”;
 - if requested, the dispatcher should call out a DAO;
 - two officers are to attend the incident and, for safety reasons, the dispatcher should maintain communication with the responding officers;
 - a “QP” (NIA check) is to be “done as a matter of course and history is to be passed to the attending personnel”; and

- if Police are not required to attend, the dispatcher should *“inform and dispatch in accord with District Mobilisation Procedures”* (which require a DAO to be called).
- for incidents involving **missing persons** where there are *“concerns for safety”*:
 - a Police unit should be dispatched to the scene (urgency depending on whether the event is coded Priority 1 or Priority 2);
 - a message about the missing person should be broadcast to all units in the search area; and
 - the field NCO (e.g. sergeant on duty) should be advised.

148. The team leader’s MSOPs in respect of events involving mentally disordered persons set out and explained the Police’s power to apprehend mentally disordered persons under the Mental Health Act and the Crimes Act. They also stated that when Police are dealing with a mentally disordered person in a private place (e.g. a residential address), a DAO should be called to examine the person unless Police are acting pursuant to section 317 or 41 of the Crimes Act 1961 (see paragraphs 130-131). The MSOPs provided that:

“DAO or Doctor at a private place has authority to request Police to:

- *use force to enter the private place;*
- *detain the mentally disordered person;*
- *take that person to a place for assessment.*

After examination, authority of a DAO (or representative) to use police transport to convey a mentally disordered person is required and the authorising DAO must accompany his or her patient.”

149. In respect of events involving missing persons, the MSOPs stated that the team leader should supervise the handling of the event, and must ensure that all risk factors have been considered and the correct action has been taken.



The Authority's Investigation

INDEPENDENT POLICE CONDUCT AUTHORITY

THE AUTHORITY'S ROLE

150. Under the Independent Police Conduct Authority Act 1988 (the Act), the Authority's functions are to:

- receive complaints alleging misconduct or neglect of duty by any Police employee, or concerning any practice, policy or procedure of the Police affecting the person or body of persons making the complaint; and to
- investigate, where it is satisfied there are reasonable grounds for doing so in the public interest, any incident in which a Police employee, acting in the course of his or her duty has caused or appears to have caused death or serious bodily harm.

151. Section 27(1) of the Act requires the Authority, on the completion of its investigation, to form an opinion on whether any Police decision, act, omission, conduct, policy, practice or procedure was contrary to law, unreasonable, unjustified, unfair, or undesirable.

THE AUTHORITY'S INVESTIGATION

152. As required under section 13 of the Act, Police notified the Authority on 20 January 2010 of the death of Mrs White.

153. The Authority assigned an investigator, who examined the Police response to the Missing Person's report from the HBC in respect of Ms Morris, including NorthComms' handling of the 111 calls.

154. The Authority has reviewed material provided by the Police, including statements from the officers involved, statements from independent witnesses, copies of the NorthComms transmissions, reviews of the incident, and relevant Police policies and standard operating procedures. The Authority has also independently interviewed the Police staff directly involved in handling the calls and in searching for Ms Morris.

ISSUES CONSIDERED

155. The Authority's investigation considered the following issues:

- 1) Did Police respond appropriately to the initial missing person notification?
- 2) Was the handling of the first call, by communicator 1 and dispatcher 1, in accordance with Police policy, standard operating procedures and related best practice?
- 3) Was Officers A and B's response to the first call reasonable in the circumstances?
- 4) Was the handling of the second call, by communicator 2 and dispatcher 1, in accordance with Police policy, standard operating procedures and related best practice?
- 5) Was the handling of the third call, by communicator 3 and dispatcher 2, in accordance with Police policy, standard operating procedures and related best practice?
- 6) Was the Police response to the third call reasonable in the circumstances?
- 7) Were the operating protocols and arrangements between Police and the Ministry of Health in respect of missing mental health patients sufficient in the circumstances and did they operate effectively?



The Authority's Findings

INDEPENDENT POLICE CONDUCT AUTHORITY

ISSUE 1: DID POLICE RESPOND APPROPRIATELY TO THE INITIAL MISSING PERSON NOTIFICATION?

156. Ms Morris left the HBC at around 10.00am, after she had threatened to kill Mrs White and had been denied her request for a discharge. In response, the HBC nurse faxed a Missing Person's Report to the HBC's designated fax number at the Hamilton Police Station watchhouse at 10.07am. This fax was not received until 11.04am because the watchhouse fax machine was being repaired (see paragraph 33).
157. Police have explained that if there is an issue with a receiving fax then the sender should automatically receive a failed transmission report. It is not clear whether a failed transmission report was generated and/or received by the HBC nurse in this case. Police did not have a contingency measure for receiving fax messages while the fax machine was being repaired.
158. The HBC nurse attempted to make a follow up phone call to the Hamilton Police Station in order to confirm that the Missing Person's Report fax had been received, but the call went unanswered. Police have not been able to explain why the call was not answered at the time; other than to say that the staff on service desks operate on a priority of work basis addressing the most urgent matter known at the time. Police say the urgency of this call could not have been known until the call was answered and an assessment made of the circumstances.
159. The Police response to this incident was thus delayed because the Missing Person's Report fax was not received and the follow-up call was not answered.
160. Since this incident Waikato Police and the HBC have changed the way missing person notifications are made. The current process is for HBC to telephone Police first, inform NorthComms and to advise that a supporting fax will be sent. The missing person job stays 'open' with NorthComms until the fax is received and any follow-up action has been taken (for further detail on National Police changes see paragraphs 240-252 of the **Subsequent Police Action** section of this report).

161. Police have advised the Authority that from 27 February 2013 Waikato District will be included in the National Crime Reporting Line (CRL) which operates 24/7. Missing person reports, including those missing or overdue from the HBC, will be reported through this service (for further detail on the CRL see paragraphs 253-255 of the **Subsequent Police Action** section of this report).

FINDINGS

The failure in Police systems led to an inappropriate response by Police to the initial Missing Person's Report. This caused a significant delay in the search for Ms Morris.

ISSUE 2: WAS THE HANDLING OF THE FIRST CALL, BY COMMUNICATOR 1 AND DISPATCHER 1, IN ACCORDANCE WITH POLICE POLICY, STANDARD OPERATING PROCEDURES AND RELATED BEST PRACTICE?

Communicator 1's actions

Handling of the call

162. The HBC nurse called 111 at 11.07am and spoke to communicator 1 at NorthComms. During this call communicator 1 obtained the basic details of the incident (see paragraph 36).
163. While this information was relevant and important, communicator 1 should have sought further information – particularly in relation to the exact nature and seriousness of the threat, Ms Morris's current mental state, her hearing disability, and the best way for Police to approach her (see paragraph 42). Such information would have been helpful to the officers dispatched to locate Ms Morris if they had encountered her.
164. When interviewed by the Authority, communicator 1 said that he now has more experience, and if the same call came in again he would spend more time dealing with it. He stated:

"... it is surprising to me that I didn't ask for the exact words of the threat. Now I'm quite thorough and it is standard practice now for me and other communicators to find out the actual mental condition of the patient. There is a chance I got a bit more focused on where [Ms Morris] was going rather than what she had said before she absconded."

165. Communicator 1 asked the HBC nurse to call back if she had any further relevant information, but did not provide her with a reference number for Event A, so as to link any subsequent calls and update the event.

166. The Authority is of the view that communicator 1 correctly obtained the basic details for Event A, but should have sought further information from the HBC nurse in respect of the threat posed by Ms Morris, her current mental state, and her hearing disability. He should also have provided the HBC nurse with a reference number for Event A.

Event creation

167. Communicators are required to accurately and concisely record the information they receive during a call and create an event in the CAD system for the dispatcher to read (see paragraphs 140-146). In this case communicator 1 created Event A and accurately recorded the event location, the headline, the caller's details, the type of event ("*Intimidation/Threats*") and the time Ms Morris had last been seen, as well as a description of Ms Morris and a brief explanation of the circumstances in which the threat was made (see paragraphs 36-38). The circumstances were such that, in the Authority's view, the event should have been designated Priority 1, rather than Priority 2.
168. The Authority accepts that Police receive thousands of calls every year about missing persons and/or persons suffering a mental disorder. Communicators 1 and 2 and dispatcher 1 all commented that they regularly deal with calls about people absconding from mental health facilities.
169. This particular call involved more than a report that a person had escaped from a mental health facility. Additional information, which increased the risks involved included that Ms Morris:
- was profoundly deaf and had NIA alerts relating to her mental health;
 - had just been denied a discharge from the HBC; and
 - shortly before her escape, had threatened to kill an identified victim.
170. It appears that the regularity with which Police staff deal with events of this nature may have led them to underestimate the risk posed by Ms Morris. This case highlights the need for consistently sound risk-assessments for such calls.
171. Pertinent to the situation was that the HBC nurse had been trying to contact Police about Ms Morris for about an hour. Communicator 1 said that he considered the event to be a Priority 2 because of the time delay (see paragraph 24), however the delay meant that Ms Morris had had the opportunity to travel towards Mrs White, the person she had threatened to kill.
172. Notwithstanding the job was designated Priority 2, Police were dispatched to the scene within minutes and the priority level does not appear to have had any impact on the outcome.

173. Communicator 1 did not record that Ms Morris was deaf, which meant that this information was not available to the dispatcher. As discussed above, communicator 1 could have sought further useful information from the HBC nurse for entry into Event A (see paragraph 163).

FINDINGS

Communicator 1 did not fully comply with Police policy, standard operating procedures and related best practice when taking information from the HBC nurse as although he accurately recorded the basic details for this incident, he should have given it a higher priority categorisation. He also should have recorded that Ms Morris was profoundly deaf and sought further information about Ms Morris and the threat she had made. These factors increased the risk level over-and-above that in a routine missing persons or absconding mental health patient case.

Dispatcher 1's actions

174. In the circumstances of this case (i.e. a missing, mentally disordered person and concerns for safety), the Communications Centres' MSOPs required the dispatcher to:
- dispatch two officers to attend the incident and maintain communication with them;
 - carry out a NIA check and pass the information on to the attending officers;
 - broadcast a message to all units in the search area; and
 - advise the sergeant on duty (see paragraph 147).
175. Dispatcher 1 read the text that was being entered into Event A while communicator 1 was on the phone with the HBC nurse, and inserted information about Ms Morris from the NIA database into the event (see paragraph 43).
176. At around 11.10am, he advised Officers A and B that they would be dispatched to look for Ms Morris at her home. The officers reported that they were en route at 11.13am, at which point dispatcher 1 advised them of the threat to kill and provided a description of Ms Morris (including the NIA alerts), but did not pass on the name of the neighbour at risk (see paragraph 50). The name of the individual under threat was a crucial piece of information that dispatcher 1 should have given to Officers A and B.
177. Police units in the area (and on the same radio channel) would have heard the message that was broadcast to Officers A and B. However dispatcher 1 did not directly advise units in the area or notify the sergeant on duty about the missing person (see paragraph 147).
178. When interviewed by the Authority, dispatcher 1 said initially that ideally he would have advised the sergeant and units in the area about Ms Morris at some stage. He pointed out

that in the text for Event B, there is an entry indicating that a message about Ms Morris was broadcast to all units – but (from listening to the audio recording of the NorthComms transmissions) this did not happen:

“A 10-1 [i.e. broadcast to all units] would normally have been done to advise the other units. I’ve reviewed the event text for [Event B] that came in which has indicated that’s been done but it hasn’t been done. I am not certain of the circumstances that led to that. I can only suppose I’ve been about to do the 10-1 broadcast but been distracted by some other event or some error has happened.”

179. Dispatcher 1 went on to say that this particular event was not a clear-cut ‘missing person’ case, because there were also mental health issues and a threat to the public. He said further: *“It’s a very regular occurrence to have mental health patients escaping from mental health care and to have various levels of reporting of that and of expectations about what Police will do to find them.”* He believed that the most appropriate course of action in the circumstances was to send a unit to check the address where Ms Morris was thought to be headed (see paragraphs 46-47).
180. Whilst dispatcher 1 followed the MSOP for ‘mentally disordered person’; the Authority is of the view that in a case such as this, where a person with known mental health issues, having been denied a discharge, had left a mental health facility soon after threatening to kill an identified individual; it was important to have units in the area on the lookout for that person. A supervisor should also have been advised about the situation – if not before Officers A and B had checked Ms Morris’s address, then at least when that check was unsuccessful. Therefore the Authority believes dispatcher 1 should have followed the MSOP for **missing persons** where there are *“concerns for safety”* (see paragraph 147).

FINDINGS

Dispatcher 1 did not fully comply with Police policy, standard operating procedures and related best practice when dispatching this event as he did not advise Officers A and B of the name of the neighbour at risk, and did not notify all units in the area and the sergeant on duty about the specific risks associated with Ms Morris.

ISSUE 3: WAS OFFICERS A AND B’S RESPONSE TO THE FIRST CALL REASONABLE IN THE CIRCUMSTANCES?

181. Officers A and B arrived at Ms Morris’s address at 11.16:28pm. This was shortly after Ms Morris had arrived at Ms Y’s house (two properties away), where she stayed for the next hour.

182. Over a period of six minutes or so, the officers spoke to a neighbour walking down the driveway, checked Ms Morris's house, and spoke to Mrs White. Both the neighbour and Mrs White were informed that Ms Morris had escaped from the HBC and were asked to call Police if they saw her. According to the officers, they also advised Mrs White that Ms Morris had reportedly threatened to harm her neighbour (see paragraphs 60-69).
183. As discussed earlier (see paragraphs 51-53), Officers A and B told the Authority that although they were aware that Ms Morris had made a physical threat against her neighbour, neither of them realised this was a threat to kill. The NorthComms communications record confirms that dispatcher 1 had advised them of the threat to kill; and Officers A and B later told dispatcher 2 that Ms Morris had *"made threats to kill her neighbours"* (see paragraph 99).
184. Officers A and B did not know the name of the neighbour who was the target of the threat and did not ask. The dispatcher had the information that the neighbour's name was Diane but did not pass this on.

185. In a Police statement Officer A said:

"We came over to [Mrs White] and asked her if she knew Christine at all and she said that she definitely did and had had previous history with her. From what she was saying it made me believe she may have been the person the threats were made against although I hadn't been told that.

Because of this I said to her 'Just be careful, she may be in the area. If you see her at all, just give us a call, don't try and talk to her at all or anything like that, just call us as soon as you can.'"

186. The Authority is of the view that the officers should have gone further than telling Mrs White to be careful; and should have taken steps to identify the neighbour who was under threat by requesting that information from NorthComms. Had the officers done so, they could have:

- gathered more information from Mrs White about Ms Morris and the history between them;
- more thoroughly assessed the risk posed by Ms Morris; and
- taken action to safeguard Mrs White.

187. In the six minutes or so that the officers were in the area, they did not speak to other neighbours, although people were at home in the two units opposite Ms Morris's. In his statement Officer A said:

“... we looked around to see if there was anybody else, any other neighbours at the houses that were close by because there were two units that were on the other side of the long driveway. I don’t know exactly what numbers they were but there was nobody outside there so we carried on.

We left the address and drove off. We got back in the car to do some Areas, just to see if we could see anybody in that area down around the streets.”

188. At 11.22:43am, Officers A and B advised dispatcher 1 that they had been unable to locate Ms Morris and left the area.
189. During a Police interview Officer B said that if they had had *“hard information”* that Ms Morris was in the area they would have knocked on more doors – however it was unlikely they would have visited Ms Y’s house because it did not have a line-of-sight view of Ms Morris’s address. He also explained that he and Officer A were influenced by what the neighbours they did speak to had told them – that Ms Morris’s house was shut up and she had not been seen for four to five days.
190. The officers were aware that Ms Morris had recently been at the HBC, which might explain why she had not been seen for a few days. They had also been told that she was likely to be heading to her home.
191. Although it may have been unlikely that the officers would have learned from Ms Morris’s immediate neighbours that she was currently at Ms Y’s house, the nature of the threat and Ms Morris’s background was such that more extensive area enquiries were warranted.
192. When interviewed by the Authority, Officer A accepted that he and Officer B could have done more area enquiries and have asked NorthComms for more information, but said that at the time their actions felt sufficient. Officer B said that he had done the best he could with the information he had: *“Perhaps I could have pressed [NorthComms] for more information but again there was nothing that indicated I needed to be concerned about.”*

FINDINGS

Officers A and B’s response to the first call was not reasonable in the circumstances. The officers should have sought more information from NorthComms about the threat and about the identity of the neighbour being threatened. They also should have conducted more extensive area enquiries in their search for Ms Morris.

ISSUE 4: WAS THE HANDLING OF THE SECOND CALL, BY COMMUNICATOR 2 AND DISPATCHER 1, IN ACCORDANCE WITH POLICE POLICY, STANDARD OPERATING PROCEDURES AND RELATED BEST PRACTICE?

193. A critical failure occurred as a consequence of how the Police handled and responded to the second call from the HBC nurse to NorthComms at 11.30am. At that time Ms Morris was at Ms Y's address, and she remained there for around 45 minutes. Due to the problems described in this section, no officers were dispatched to apprehend and prevent Ms Morris carrying out her threat against Mrs White.

Communicator 2's actions

Handling of the call

194. After Ms Y had advised the HBC nurse that Ms Morris was currently at her house, the nurse called NorthComms, at 11.30am, and spoke with communicator 2, saying she was calling *"to report about our missing person"*.

195. When receiving a call about an event that has already been entered into the CAD system, the communicator should update the existing event with the new information, provided the caller is the original informant (see paragraph 145). In this case communicator 2 did not realise that the HBC nurse had called earlier, and that there already was an event associated with the matter, Event A.

196. Communicator 2 created Event B in the CAD system and proceeded to ask the HBC nurse a series of questions about her contact details, and from where and when Ms Morris had gone missing. During this questioning the HBC nurse attempted to tell communicator 2 about the call she had received from Ms Y, but the communicator ignored this and carried on asking how Ms Morris had left the HBC.

197. About halfway through the call, communicator 2 realised that the nurse was calling to report the known location of Ms Morris. She continued questioning the nurse, obtaining a description of Ms Morris and clarifying the location of the neighbour who had been threatened. The nurse indicated that the HBC was *"thinking [Ms Morris] might not act out but we just have to take the precautions."* The call ended at about 11.35am (see paragraphs 76-82).

198. As with the first call, communicator 2 did not question the HBC nurse further about Ms Morris's profound deafness, her mental state, or the exact nature of the threat (see paragraph 163). Nor did she ask for the name of the neighbour who was the subject of the threat.

199. In a Police statement, communicator 2 said:

“Once I established that the missing person was at a specific location I entered this into the job. I saw that there was already a job coded Threats/Intimidation [Event A]. I believed that the information I provided was third hand at the time and other than the location being re-flagged I didn’t believe that any other information provided by the informant was new or additional information.

I don’t believe at the time I was required to explore the critical issues once identified, as there was already a job in the system.”

200. When interviewed by the Authority, communicator 2 further explained that she had discussed Event B with dispatcher 1 (near the beginning of the call), and he had told her that he already knew about the incident and Ms Morris’s address had been checked. Because dispatcher 1 already knew about the incident, communicator 2 thought she did not need to get any further information from the nurse.
201. Communicator 2 did not appreciate the significance of the new information provided by this call – that Ms Morris was at a location near her home, and was therefore in close proximity to the person she had threatened to kill. She did not upgrade the priority level of the event or advise dispatcher 1 that Ms Morris’s location was known. The Authority accepts that communicator 2’s perception of the seriousness of the threat may have been influenced by the HBC nurse’s comment that they were just taking precautions and Ms Morris “*might not act out*” (see paragraph 81). The communicator nevertheless did not seek all relevant information and did not deal expeditiously with the information she did receive. The result was a missed opportunity to apprehend Ms Morris.
202. When interviewed by the Authority, communicator 2 said that, in hindsight, she believed she should have tried to obtain the contact details for Ms Y and called her directly to obtain more information. This would have meant that she was not dealing with second-hand information and would have enabled her to better understand the situation.
203. Communicator 2’s handling of the call had a direct impact on how details for Event B were recorded, as discussed below.

Event creation

204. Communicator 2 entered the information she obtained from the HBC nurse into Event B in the CAD system (see paragraphs 76-82). The headline of the event, created before she realised the true purpose of the call, was: “*MORRIS/CHRISTINE GONE AWOL*”. This did not accurately convey the critical information from the call, which was that Ms Morris was known to be at Ms Y’s address.
205. The time that Ms Morris had last been seen was entered into Event B as 10.00am. This was incorrect, Ms Morris having been seen by Ms Y within the last few minutes. Event B

was coded as “Missing Person”. A more appropriate code would have been “Intimidation/Threats”, because that was the issue of most concern. Furthermore, the event should have been designated Priority 1, because Ms Morris was close to her stated target’s home.

206. In her statement, communicator 2 said:

“At the time of the call I didn’t think I was premature or wrong in the evaluation of the call. The call automatically came up as from Henry Bennett Centre and the caller said they were from Henry Bennett Centre. The caller advised she was calling about “our missing person”. That was why it was flagged as [Missing Person].

...

All information relating to a missing person, whether being reported as missing, being at a location, or having been located, we code as [Missing Person].”

207. As discussed in paragraphs 74-75, the location of the event was automatically recorded as the HBC and was not immediately changed because communicator 2 did not yet realise that the HBC nurse was calling to report that Ms Morris was at a particular address. As a result, the nearby event warning safety feature in the CAD system did not operate.

208. Communicator 2 has said that she realised Event A existed when she changed the location for Event B from the HBC to Ms Y’s address partway through the call (see paragraph 199). She did not consider cancelling the event and creating a new one to merge with Event A:

“I hadn’t thought of entering a new event. The information I was getting was still second hand, and the earlier event had detailed the same information. I didn’t believe I needed to enter a new job or re-code [Event B] as my caller was from Henry Bennett Centre and not from [Ms Morris’s neighbourhood].”

209. The HBC nurse had mentioned that Ms Morris was profoundly deaf but communicator 2 did not enter this information into the text for Event B.

210. Crucially, the vital information from the call – that Ms Morris was currently at Ms Y’s address, was entered only near the end of the text (see paragraph 82).

211. Overall, much of the key information in Event B (the headline, the code, the priority level, the time Ms Morris had last been seen, and the initial event location) was misleading or inaccurate – which appears to have affected dispatcher 1’s understanding of and response to the event.

212. In summary, the Authority is of the view that communicator 2 misunderstood the purpose of the HBC nurse's call initially. This led her to create Event B, which appeared to be a report of a missing person, rather than a report that a missing person's location was known and that the person should be apprehended. Consequently, some of the information recorded in Event B was misleading and inaccurate. When communicator 2 realised the purpose of the call, she should have created a new event that was structured correctly and included the new information, and then merged this event with Event A. She also should have taken the opportunity to seek more information about the threat posed by Ms Morris.

FINDINGS

Communicator 2's overall handling of the second call from the HBC was poor and was not in accordance with Police policy, standard operating procedures and related best practice. Some of the information she recorded was misleading and inaccurate. When communicator 2 realised the purpose of the call she should have created a new record, structured correctly with the new information included.

Dispatcher 1's actions

213. Dispatcher 1 read the information recorded in Event B and thought the event was another report about Ms Morris being missing. He did not note the additional information that required further action to be taken (see paragraphs 85-87). The change in the event location partway through the call and the comment near the end of the text about Ms Morris being at Ms Y's address did not register with dispatcher 1 as new information, despite the alerts that appeared on his screen showing that the event had been updated with new information (see paragraph 119). As a result he did not dispatch officers to apprehend Ms Morris.
214. When asked how he had missed the change in the event's location and the information that Ms Morris was at Ms Y's address, dispatcher 1 said:

"I can only suppose what may have led to that happening. There were a number of factors, a number due to the technical nature of the [CAD] system at that time and when those details changed in the system. Some of it was to do with the wording and my understanding of the job up to that point.

Reading the event until about half way read as something different to what it turned about to be, which was the current location of that person [i.e. Ms Morris]. It came towards the end and by that stage I had formed the opinion on the information we already had and in discussion with [communicator 2] directly that this was [the HBC] ensuring we had

the information about the fact the person was missing and that we were taking some action – as evidenced by my updates in the text e.g. what the unit had done thus far.”

215. Believing Event B to be a duplicate event (i.e. one which requires no further action to that already taken in response to an earlier event), dispatcher 1 added commentary to Event B, explaining that officers had checked Ms Morris’s address but she had not been there for five days. He then cross-referenced Event B to Event A.

216. In his statement dispatcher 1 said:

“... I was cross-referencing [Event A] and [Event B] at 11:35:12 and I may not have seen the call-taker’s 11:34:30 comments [that Ms Morris was at Ms Y’s address] if I was cross-referencing from the primary Event, [Event A]. They may not have appeared on my screen at all. When the cross-reference process was complete I added comments about the unit having attended the address. There may have been system comments showing and the call-taker’s 11:34:30 comments may not have been the last portion of event text visible to me. The comments would have been able to be scrolled back to, but I would only do that if I knew there was something to go back and look for.

If there was nothing else going on I would likely go back and look at the whole job’s text before merging or resulting, but I was due for a break and did a hand-over shortly after cross-referencing the jobs. Having listened to the Radio Channel recordings I was busy in the meantime with person checks and dispatching events for other patrols.”

217. Having considered dispatcher 1’s statements and the assessments provided by Police in respect of dispatcher 1’s actions in response to the second call (see paragraphs 118-120), the Authority is of the view that dispatcher 1’s failure to send officers to Ms Y’s address to apprehend Ms Morris was caused partly by his poor assessment of information and partly by deficient call handling by communicator 2 (see paragraphs 194-212).

218. In summary, the Authority finds that dispatcher 1 missed the key piece of information in Event B – Ms Morris’s current location. This resulted in a failure to dispatch officers to locate Ms Morris before she could carry out her threat against Mrs White.

FINDINGS

Dispatcher 1 did not act in accordance with Police policy, standard operating procedures and related best practice when dispatching the second call. He missed the key piece of information which was Ms Morris’s current location. This resulted in a failure to dispatch officers to locate Ms Morris before she could carry out her threat against Mrs White.

ISSUE 5: WAS THE HANDLING OF THE THIRD CALL, BY COMMUNICATOR 3 AND DISPATCHER 2, IN ACCORDANCE WITH POLICE POLICY, STANDARD OPERATING PROCEDURES AND RELATED BEST PRACTICE?

Communicator 3's actions

Handling of the call

219. Ms Y telephoned 111 at 12.19pm to report that Ms Morris had just left her house, having been there for the previous hour. She spoke to communicator 3 and told her she was calling about “*an escaped Henry Bennett patient*”. Communicator 3 and Ms Y then discussed what had occurred while Ms Morris had been at Ms Y's house, and what Ms Y had seen Ms Morris do since she left her house. While still on the line, Ms Y informed communicator 3, at 12.23pm, that Ms Morris had returned with blood on her face, and said she could see a bloodstained hammer on her neighbour's doorstep.
220. Communicator 3 kept Ms Y on the line so she could describe what Ms Morris was doing. Eventually Ms Morris walked away from Ms Y's house, along the street and out of sight. The 111 call ended at 12.34pm, after communicator 3 had given Ms Y the reference number for Event C and asked her to call back if Ms Morris returned (see paragraphs 91-101).

Event creation

221. Upon receiving the call from Ms Y, communicator 3 created Event C in the CAD system. The event was coded as “*Mental [Health]*” and initially labelled Priority 2, with the headline “*INFMT [informant] FOUND ABSCONDED 1M [mental health patient]*”. This headline accurately reflected the crucial information from the call.
222. Communicator 3 correctly recorded the event location (Ms Morris's address), Ms Y's details, and the time when Ms Morris was last seen (5 minutes ago), in addition to other information about Ms Morris that was provided by Ms Y. At 12.23:53pm, after Ms Y advised her that Ms Morris had returned with blood on her face, communicator 3 took appropriate action by upgrading the event to Priority 1.

FINDING

Communicator 3 correctly handled the third call in accordance with Police policy, standard operating procedures and related best practice.

Dispatcher 2's actions

223. Dispatcher 2 acknowledged receipt of Event C at 12.20:06pm and read the information associated with the event as it was entered by communicator 3. When the priority level was upgraded at 12.23:53pm, she immediately notified the sergeant on duty of the incident and explained that Ms Morris had been seen with blood on her face.
224. Dispatcher 2 then arranged for several other Police units to attend the scene, including Officers A and B and a dog unit (see paragraphs 98-99). Given the seriousness of the incident, this was an appropriate response.

FINDING

Dispatcher 2 acted in accordance with Police policy, standard operating procedures and related best practice when dispatching the third call.

ISSUE 6: WAS THE POLICE RESPONSE TO THE THIRD CALL REASONABLE IN THE CIRCUMSTANCES?

225. Following dispatcher 2's radio message, Police units responded to the area to locate Ms Morris. Officers A and B arrived shortly after Ms Y's 111 call ended (at 12.34pm) and began searching the neighbourhood.
226. At around 12.40pm Officer B discovered that Mrs White had been attacked in her home. An ambulance was called but Mrs White had died at the scene as a result of her injuries.
227. Ms Morris was apprehended close-by at 12.52pm. She was arrested and later charged with the murder of Mrs White (see paragraphs 103-105).
228. Police took appropriate action to locate and arrest Ms Morris.

FINDING

The Police response to the third call was reasonable in the circumstances.

ISSUE 7: WERE THE OPERATING PROTOCOLS AND ARRANGEMENTS BETWEEN POLICE AND THE MINISTRY OF HEALTH IN RESPECT OF MISSING MENTAL HEALTH PATIENTS SUFFICIENT IN THE CIRCUMSTANCES AND DID THEY OPERATE EFFECTIVELY?

229. None of the Police staff involved in the response to Ms Morris leaving the HBC raised the issue of the potential need for a DAO to be involved when officers went to apprehend and transport her back to the HBC (see paragraphs 57-58). When interviewed by the Authority communicator 2 said:

“That’s not my role. It’s HBC’s role. It’s their job to make sure a DAO goes. Only when a DAO is at an address can they call us to help with taking the patient. ... DAOs will ring us and ask for assistance with transport if the patient is violent or anything. They turn out because they request us to attend [to transport the patient].”

230. When asked in a Police interview when Communications staff would call out a DAO, communicator 2 said:

“Generally we only call the DAO’s when the I-car [Police patrol unit] has requested us to do so. I am aware of the requirement for presence of DAO’s whenever Police use powers to detain or transport. Usually it is the DAO’s that request Police assistance with transportation to hospitals etc.”

231. When interviewed by the Authority, dispatcher 1 said:

“The practical situation doesn’t line up with how the MOU should work between us and Mental Health. I understand Mental Health is supposed to take a much more active role in managing mental health patients than they actually do. When they ask for our assistance they are often not even there. In my experience it takes on average an hour to 1.5 hrs to get a response from a DAO – I mean overall in the whole NorthComms area – not Waikato in particular. I suggest the response in Hamilton between Police and Henry Bennett is slightly better than say in Auckland.”

232. As discussed earlier, section 41 of the Mental Health Act gives Police the power to enter a property and transport a mental health patient to hospital – but only when they have been called to assist a DAO (see paragraph 127). Police policy also states that a DAO should be called when a mentally disordered person is in a private address, unless Police are acting under sections 41, or 317 of the Crimes Act (see paragraphs 130-131, 136 and 148).
233. In this case, by the time officers had located Ms Morris, her actions had negated the need to seek a DAO’s attendance.
234. Nonetheless, this case highlighted a gap in Police policy; and in the national and local MOUs between Police and Health Services in respect of what actions should be taken when a mental health facility reports that a patient is missing or absent without leave; and what should happen when that patient is located and Police are required to transport him or her back to hospital.
235. The Authority notes that Police have taken action to rectify this situation. In January 2012 Police clarified their *“People with Mental Impairments”* policy. This policy now describes

the actions that should be taken when a patient is reported absent without leave, including a requirement to consult a DAO. In December 2012 Police signed a new MOU with the Ministry of Health covering the responsibilities of each agency in connection to people with mental health and addiction problems. For further detail on this and other developments see the **Subsequent Police Action** section of this report below.

FINDINGS

At the time of this incident, operating protocols and arrangements between Police and the Ministry of Health in respect of missing mental health patients were insufficient and did not always operate effectively. However Police have since taken action to remedy this, as detailed in the **Subsequent Police Action** section of this report.



Subsequent Police Action

INDEPENDENT POLICE CONDUCT AUTHORITY

DISCIPLINARY MATTERS

236. Police reviewed the actions during this incident, of Officers A and B, communicators 1 and 2 and dispatcher 1, and determined there were no criminal or Police Code of Conduct matters to be addressed.
237. Since the incident, the performance of the NorthComms staff involved has been monitored and assessed regularly as part of a new Quality Assurance process (see paragraphs 240-241).

POLICE REVIEW RECOMMENDATIONS

238. The Police Policy, Practice and Procedure review of this incident (see paragraphs 250-252) made a number of recommendations relating to training, line control and standard operating procedures for Police Communications Centres. The Police reviewer also recommended that Police:
- i) review the Memorandum of Understanding between Police and the Ministry of Health; and
 - ii) insert into the Police Manual, a section regarding mental health patients who have gone missing or are absent without leave, *“defining responsibilities and process to be followed, particularly relating to dangerous patients who pose a threat to society and/or themselves.”*
239. All of these recommendations have been addressed or are in the process of being addressed by Police. Specific changes to Communications Centres and to policies are detailed below.

Communications Centres

240. At the time of this incident, there was no policy governing Quality Assurance (QA) processes for communicators and dispatchers at Police Communications Centres.
241. A QA policy has since been approved by the National Operations Manager: Police Communications Centres, and the performance of communicators and dispatchers in the three Police Communications Centres (Northern, Central and Southern) is now assessed against national standards. Under the QA programme, communicators and dispatchers receive regular one-on-one coaching and feedback sessions with QA Assessors.
242. The Police Training Services Centre is currently undertaking a review of the initial call handling training of Communications Centre staff, including an examination of best overseas practices. It is expected that this review will be completed by the end of 2012.
243. There have also been changes in the CAD system since January 2010, including that events are now updated automatically instead of the dispatcher having to seek updates (see paragraph 122).

Policy changes

244. Since this incident, Police have engaged in discussions with the Mental Health Directorate of the Ministry of Health. In December 2012 they finalised a new Memorandum of Understanding, which includes specific service requirements for both agencies when working together on incidents involving a person with a mental disorder.
245. On 26 January 2012, Police published the latest version of their “People with mental impairments” policy. It includes a section titled “Returning a patient to hospital who is absent without leave”, which sets out the steps to be taken when a mental health patient is reported missing or absent without leave:

Step	Action
1	<p><i>Notification. It is expected that police will be initially notified by phone of the escape of a patient, to be promptly followed by a faxed notification.</i></p> <p><i>When receiving a call ascertain:</i></p> <ul style="list-style-type: none"> • <i>if the patient is considered a threat to themselves or others and the extent of any threat</i> • <i>whether the patient has any weapons</i> • <i>if it is known where the patient may be located or where they may be going and;</i> • <i>request a faxed notification.</i>
2	<p><i>Enter them as ‘missing’ in NIA as a Person Alert.</i></p> <p>Note: <i>Decisions on the level of further Police action are made in the same way as for other persons reported missing but with high priority for those considered to pose a threat.</i></p>
3	<p><i>Consult a DAO about:</i></p> <ul style="list-style-type: none"> • <i>the action to take</i> • <i>whether a press release is needed</i>

	<ul style="list-style-type: none"> • the level of police assistance required • whether the patient is likely to suffer harm • whether the patient is likely to harm other people or damage property • the DAO attending the location when it is believed a patient considered to be a threat can be located.
4	Keep a written record of all consultations with health authorities, taking particular note of the assistance sought and the level of possible threat.

246. The policy also sets out the steps Police must take when asked to return a patient to hospital:

Step	Action
1	Check the status of the patient with the Communications Centre or the informant and ensure that the information is recent and accurate.
2	Find out whether: <ul style="list-style-type: none"> • there is any history of violence • the patient has been taking drugs • there is any likelihood that the patient has any form of weapon • it is considered that the patient poses any threat to themselves or others • there is any indication of where the patient may be going to or may be found.
3	Obtain documentary evidence of the absence without leave before you retake the person.
4	Where the patient is considered to pose a threat or considered dangerous, a DAO should be requested to meet and assist police at the address where it is believed the patient can be located. Note: Circumstances may require police to act before a DAO arrives or if a DAO is unavailable.
5	Before collecting the person, ensure that you are familiar with the procedures on transporting a person and your powers to use force.
6	Advise the patient of their rights under the <u>New Zealand Bill of Rights Act 1990</u> .

247. There is also a section in the policy titled “Mentally disordered person on private property”, which explains that: “If a mentally disordered person is causing problems in a private place, you have **no** power to enter or detain under the Mental Health Act, unless asked to do so by a DAO or medical practitioner [emphasis in original].”

248. The section goes on to identify other legislation which may empower Police to enter the property, depending on the circumstances (i.e. sections 41 and 317 of the Crimes Act, and the Trespass Act). If none of these Acts are applicable, then Police are required to call a DAO or medical practitioner to the scene before taking action.

249. The Communications Centres MSOP for mentally disordered persons has been updated to reflect the new policy. Communicators are now required to ask whether the person involved is a committed patient, and if so; whether they are considered a risk to themselves or others, and the location where they can be found or may be headed.

Dispatchers are also required to request that a DAO attend the scene with Police – but only when the patient is considered to be a threat to themselves or others.

POLICE REVIEW OF THEIR RESPONSE TO PEOPLE WITH MENTAL IMPAIRMENT

250. In July 2012, the New Zealand Police Organisational Assurance Group completed a review of the Police response to incidents involving persons with mental impairment. This review examined the operational impacts on policing arising from contact with persons with mental impairment, and sought to identify gaps in knowledge and skill and to find ways to improve service delivery with key stakeholders.

251. The review found (amongst other things) that:

- Police deal with around 20,000 calls for service per year relating to people who are mentally impaired and/or suicidal, and this number is increasing at a rate of approximately 1165 per year.
- Officers regularly detain people who are mentally impaired and/or suicidal without proper legal authority – but they have good intentions when doing so (i.e. trying to ensure the safety of that person and others).
- Police regularly receive reports about mental health patients who have gone missing from treatment facilities and devote time and resources to dealing with these reports.
- Most officers are not aware of the “*People with mental impairments*” chapter of the Police Manual.

252. The review made 53 recommendations for Police, including the following:

- Recommendation 2: Determine whether a change in the law or in Police operational practice is needed in respect of Police entering private premises and detaining a mentally disordered person.
- Recommendation 3: Negotiate a commitment from the Director of Mental Health so that:
 - the Ministry of Health provides enough resources to ensure that DAOs are able to provide an emergency response; and
 - Police officers are only deployed to mental health crisis events where there is a risk to the life or safety of any person (i.e. an emergency response is required), or upon request from a DAO.

- Recommendation 4: Develop training for shift sergeants about the limitations of Police powers under the Mental Health Act.
- Recommendation 25: Determine whether additional training in relation to mental health issues and suicide risk should be provided to officers.
- Recommendation 29: Develop and distribute 'aide memoires' for officers that describe the key steps to take when responding to incidents involving mentally disordered persons.
- Recommendation 31: Update local MOUs once the new national MOU between Police and the Ministry of Health has been authorised.
- Recommendation 33: Run a national hui with key stakeholders to identify prevention-focused solutions to mental health issues.
- Recommendation 41: Review international best practice in relation to Health services and Police working together to deliver emergency response mental health services.
- Recommendation 49: Investigate the possibility of rostering DAOs and specialist intellectual disability personnel to Police communications centres to give advice to staff dealing with incidents involving mental health issues and to help with making formal requests for Police assistance under section 41 of the Mental Health Act.

POTENTIAL USE OF CRIME REPORTING LINE

253. Originally designed as a designated crime reporting service to receive and action non-emergency calls, the Crime Reporting Line (CRL) operates 24/7. The aim is to reduce the pressure on the 111 system.
254. The CRL started in Auckland and Bay of Plenty Districts in 2006. It has now been introduced in Counties-Manukau (2009) and Canterbury and Eastern Districts (2012). The Police National Manager: Communications Centres has recently advised the Authority that the CRL will be introduced into the Waikato district in February 2013. Police plan to roll-out the CRL through all remaining Police districts by June 2013.
255. Currently, missing person reports, including those missing or overdue from mental health facilities, are not reported through the CRL. Instead the caller telephones the local Police station or communications centre via the 111 system. However, the Authority considers that all mental health patients who are missing or absent without leave should be reported to Police by way of a notification to the CRL; this would ensure a consistency of approach and a timely triage and risk assessment by specially trained people.



Conclusions

INDEPENDENT POLICE CONDUCT AUTHORITY

256. Police had the information and the ability to prevent the death of Mrs White. Had Police responded appropriately to the available information Mrs White's death could have been prevented.
257. The key Police failure in this case was that officers were not dispatched to apprehend Ms Morris at Ms Y's address after the second call from the HBC nurse. If that had occurred, it is likely that Mrs White's death would have been prevented.
258. The Police response to this incident was inadequate in a number of other respects:
- the failure to respond to the initial fax notification and the follow-up phone call from the HBC nurse;
 - communicator 1's lack of questioning during the first call (regarding the threat and Ms Morris's mental state and hearing disability);
 - in relation to the first call, dispatcher 1's failure to advise Officers A and B of the name of the person being threatened, and his failure to notify the sergeant on duty and all units in the area about the threat posed by Ms Morris;
 - inadequate area enquiries by Officers A and B in response to the first call and their failure to seek more information about the identity of the person under threat;
 - communicator 2's poor handling of the second call – including a lack of questioning and the recording of inaccurate and misleading information in Event B;
 - in relation to the second call, dispatcher 1's failure to read the key piece of information in Event B, and his subsequent failure to dispatch officers to apprehend Ms Morris; and the Police's failure to consult a DAO about the situation with Ms Morris; and
 - the failure to consult a DAO, particularly when Ms Morris's location became known.

Section 27 opinion

259. Section 27(1) of the Independent Police Conduct Authority Act 1988 (the Act), requires the Authority to form an opinion as to whether or not any act, omission, conduct, policy, practice or procedure the subject-matter of an investigation was contrary to law, unreasonable, unjustified, unfair or undesirable.
260. Having regard to the factors in paragraphs 257 and 258, in terms of section 27(1) of the Act, the Authority has formed the opinion that the following matters were unreasonable and unjustified:
- i) the failure of Officers A and B to conduct more extensive enquiries; and
 - ii) communicator 2's poor handling of the second call to Police.
261. Having regard to the factors in paragraphs 257 and 258, in terms of section 27(1) of the Act, the Authority has formed the opinion that the following matters were undesirable:
- i) the Police's failure to respond to the initial fax notification and follow-up call from the HBC;
 - ii) communicator 1's inadequate handling of the first call to Police;
 - iii) dispatcher 1's inadequate response to the first call to Police; and
 - iv) dispatcher 1's failure to read the key piece of information in Event B, and his subsequent failure to dispatch officers to apprehend Ms Morris; and the Police's failure to consult a DAO about the situation with Ms Morris.

Recommendations

INDEPENDENT POLICE CONDUCT AUTHORITY

262. In the course of its investigation, the Authority has considered whether the officers and communications centre staff involved in this matter should have been the subject of disciplinary action. Police have advised that they have taken remedial action in connection with several staff. In view of the very clear findings contained in this report, the Authority confines itself to noting the action taken by Police.
263. The Authority notes that Police have taken action since 19 January 2010 to improve:
- the arrangements between Police and the Ministry of Health by clarifying each agency's responsibilities when a mental health patient is reported missing;
 - Police policy in respect of *People with mental impairments*; and
 - the training and performance of communicators and dispatchers in all Communications Centres.
264. The Authority supports the recommendations made in the Police review of their response to people with mental impairment. In particular, the Authority supports further training to all staff (front-line and communication centres) on Police legal powers and the *People with Mental Impairments* policy. The Authority also supports the continued roll-out of the CRL to all Police districts.
265. Pursuant to section 27(2) of the Act, the Authority recommends that the New Zealand Police use the CRL for the notification to Police of missing, or absent without leave, mental health patients.



JUDGE SIR DAVID CARRUTHERS
CHAIR
INDEPENDENT POLICE CONDUCT AUTHORITY

28 February 2013

About the Authority

WHAT IS THE INDEPENDENT POLICE CONDUCT AUTHORITY?

The Independent Police Conduct Authority is an independent body set up by Parliament to provide civilian oversight of Police conduct.

It is not part of the Police – the law requires it to be fully independent. The Authority is overseen by a Board, which is chaired by Judge Sir David J. Carruthers.

Being independent means that the Authority makes its own findings based on the facts and the law. It does not answer to the Police, the Government or anyone else over those findings. In this way, its independence is similar to that of a Court.

The Authority has highly experienced investigators who have worked in a range of law enforcement roles in New Zealand and overseas.

WHAT ARE THE AUTHORITY'S FUNCTIONS?

Under the Independent Police Conduct Authority Act 1988, the Authority:

- receives complaints alleging misconduct or neglect of duty by Police, or complaints about Police practices, policies and procedures affecting the complainant;
- investigates, where there are reasonable grounds in the public interest, incidents in which Police actions have caused or appear to have caused death or serious bodily harm.

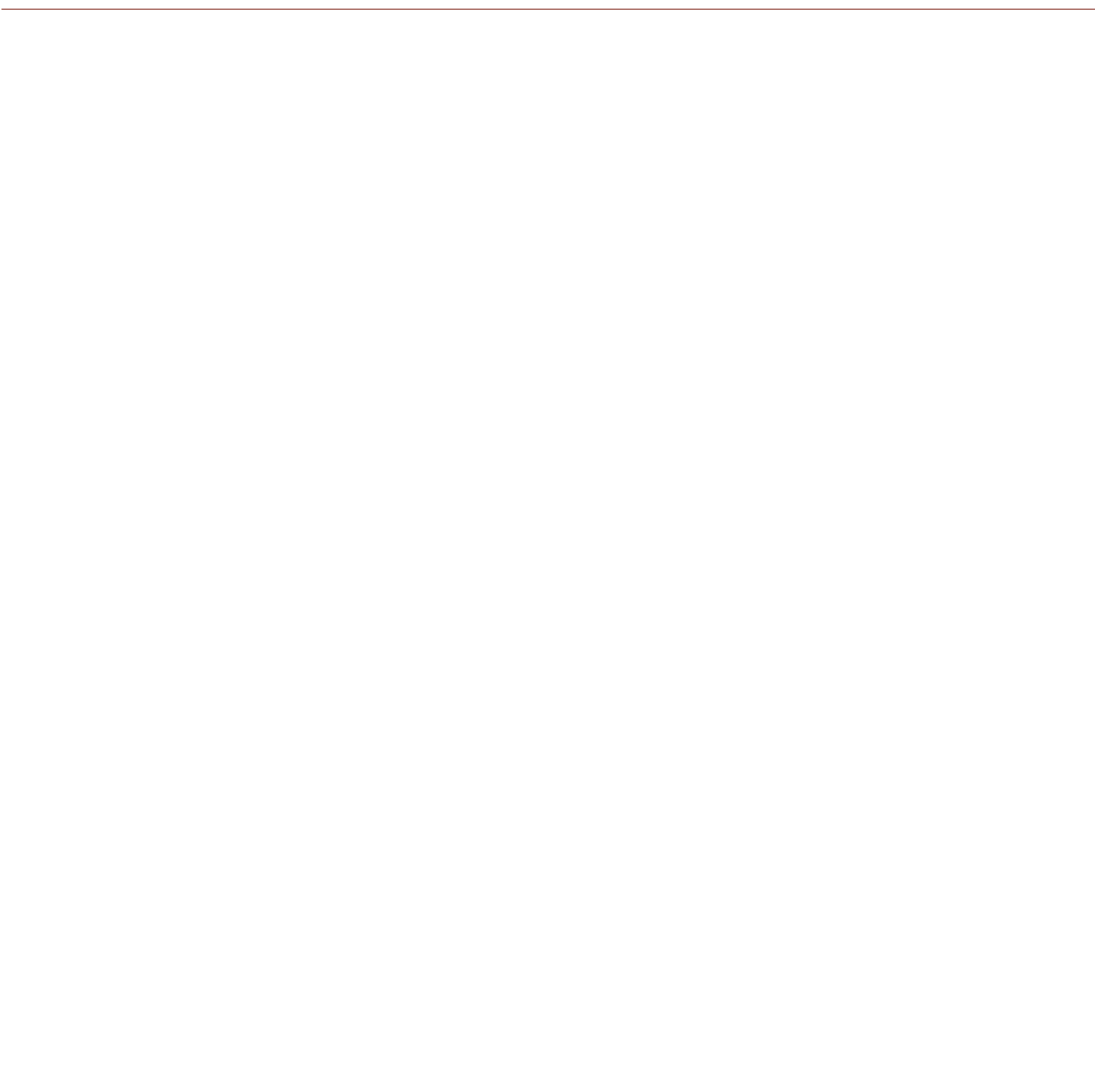
On completion of an investigation, the Authority must determine whether any Police actions were contrary to law, unreasonable, unjustified, unfair, or undesirable. The Authority can make recommendations to the Commissioner.



PO Box 5025, Wellington 6145

Freephone 0800 503 728

www.ipca.govt.nz





IPCA
Level 8
342 Lambton Quay
PO Box 5025
Wellington 6145
Aotearoa New Zealand
0800 503 728
P +64 4 499 2050
F +64 4 499 2053
www.ipca.govt.nz